ASSURING SAFE AND INTEGRATED HEALTH CARE

A review of the risks, benefits and regulatory requirements for the professions of naturopathy and Western herbal medicine

A research report commissioned by the members of the Australian Naturopathic Council.

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DEDICATION

This report is dedicated to our dear friend, colleague and co-author **Professor Emeritus Stephen P. Myers**. Stephen's visionary leadership, intellect, passion and commitment to naturopathy is sorely missed. Stephen continues to inspire us all to step up and fill the gap.

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SUMMARY REPORT

INTRODUCTION

Demand for the health care services provided by naturopaths and Western herbal medicine practitioners (herbalists) has been a consistent feature of the Australian healthcare landscape for generations. Each year, a sizeable proportion of Australian consumers choose to see a naturopath or herbalist to help maintain their health, prevent illness, and treat acute and chronic health conditions. This is a picture that has remained largely consistent over time.

Naturopaths and herbalists are a non-registered workforce, operating principally in private practice, outside the public health system. They provide services to patients from all demographics and across most parts of the country. As such, they represent a largely untapped public health resource with the capacity to make a far greater contribution to primary and preventive health care, to keep people healthy. However, efforts to better integrate naturopaths and herbalists into the public health and primary care service systems confront institutional and attitudinal barriers, with questions about the risks and benefits of their treatments and practices.

In 2021, the Australian Naturopathic Council (ANC) commissioned Dr Anne-Louise Carlton, a research fellow from RMIT University, to gather a group of researchers to undertake a study of the regulatory requirements for the professions of naturopathy and Western herbal medicine (WHM).

The purpose of this study was to investigate and understand the practice of naturopathy and WHM in Australia and to make recommendations on the need, if any, for measures to strengthen regulation, to better protect public health and safety and improve the health of the population. The brief was to build on an earlier government-commissioned study published in 2005 (Lin et al., 2005) (the Lin Report).

The results of the present study are expected to inform the preparation of a submission from ANC member organisations to state, territory, and federal Health Ministers, seeking the inclusion of naturopaths and herbalists in the National Registration and Accreditation Scheme for the health professions (NRAS) – the statutory scheme under which the members of many health professions are registered and regulated.

METHODS

The methods adopted for each component of this study are listed in Table 1. The methods included:

- reviews of published literature (including systematic reviews)
- reviews of grey literature including government reports and policy documents, laws and regulations
- reviews and analyses of administrative and complaints data from regulators, and
- primary data collections through surveys

Table 1: Components and methods of the project

Component	Methods
Chapter 2: Consumer expectations and use of naturopathy and Western herbal medicine	• Systematic review of the published literature from bibliographic databases • Data extracted using Covidence
Chapter 3: Risks associated with the practice of naturopathy and WHM	• Bibliometric analysis of Ovid MEDLINE from 1950 to 2022 • Search for court judgements, tribunal decisions, and coronial inquest findings sourced from legal databases and websites • Search of websites and annual reports of State and Territory health complaints entities (HCEs) • Data from professional bodies on complaints received • Information from education providers on curriculum resources regarding adverse effects of herbal and nutritional medicines
Chapter 4: The benefits of naturopathy and WHM	• Bibliometric analysis of Ovid MEDLINE from 1971 to 2021 • Critical review of government reports and systematic reviews from 2000-2022
Chapter 5: The naturopathy and WHM workforce	• Systematic review of bibliographic databases • Data extracted using Covidence
Chapter 6: Education of naturopaths and herbalists for entry to practise	• Survey of tertiary education providers • Search of tertiary education provider websites • Thematic analysis
Chapter 7: Professional representative arrangements for naturopaths and herbalists	• Survey of professional representative bodies • Website searches and information sourced from health funds and key informants to identify professional associations • Search of professional representative body websites
Chapter 8: Institutional recognition of and support for the naturopathy and WHM professions	• Information sourced from Lin Report • Website searches of policies, plans, reports, and committees of relevance • Direct contact with institutions • Thematic analysis
Chapter 9: Regulation of the naturopathy and WHM professions	• Search for relevant Acts and regulations • Internet search for information and reports published since 2005 on health practitioner regulation models, policy, and legislative proposals by health and consumer affairs authorities in the Australian Government and each state and territory • Information sourced from World Naturopathic Federation report ***Naturopathy practice, effectiveness and safety*** (Lloyd et al., 2021)
Chapter 10: Assessing the need for stronger regulation of the naturopathy and WHM professions	• Thematic analysis • Assessment and synthesis of data from Chapters 2-9 against the AHMAC/Intergovernmental Agreement (IGA) criteria.

KEY FINDINGS AND RECOMMENDATIONS

The key findings and recommendations of the study are summarised below.

Definition of practice and scope of study

This study is concerned only with naturopathy and WHM and does not consider a range of other practices (such as kinesiology, reflexology, iridology, reiki, Bach flower therapy, aromatherapy, Ayurvedic medicine, and so on).

Definitions of key terms used in the report are set out below. In the absence of competency standards published by the World Naturopathic Federation, these definitions reference the competency standards for naturopaths and Western herbal medicine practitioners that have been published by ARONAH in 2021 (for naturopaths) and 2019 (for Western herbal medicine practitioners). While we acknowledge there is not broad consensus among professional associations and education providers about competency standards for these professions, the ARONAH standards represent the only comprehensive set of competency standards available that have been developed specifically to apply in the Australian practice setting:

Naturopathy

Naturopathy, also called naturopathic medicine, is a medical system that has evolved from a combination of traditional practices and health care approaches popular in Europe during the 19th century.[1] It is defined by its core principles of holism and vitalism, and its practice is guided by distinct naturopathic theories. Its body of knowledge is extensively documented and it is widely practised as a profession in many countries.

Naturopath

For the purposes of this study, a naturopath is a health practitioner who has:

1 See Lin & colleagues (2005: 24-26) for a summary of the evolution of the practice of naturopathy & WHM.

- completed core training in naturopathic principles, history, theories and philosophy, as well as in at least three of five practice modalities: (i) herbal medicine; (ii) clinical nutrition (iii) applied nutrition; (iv) manual therapies; and (v) exercise therapy; and
- achieved the competencies as described in the Australian Register of Naturopaths and Herbalists (ARONAH) *Competency Standards for Naturopathic Practitioners*.[2]

The qualifications for entry to practice as a naturopath would generally be at AQF Level 7 or equivalent with provision for the grandparenting of practitioners with historic qualifications who can demonstrate a record of safe practice.

While the modalities encompassed by naturopathy also may be practised as single modalities, this study does not encompass those practitioners whose training and practice is in a single modality of massage, clinical nutrition (sometimes called 'nutritional medicine'), homeopathy, or counselling.

Western herbal medicine practitioner (herbalist)

For the purposes of this study, a WHM practitioner is a person who provides health services that involve the extemporaneous compounding of herbs for therapeutic purposes for individuals under their care, and has:

- satisfactorily completed core training in Western herbal medicine principles, history, theories, philosophy and practice, and
- achieved the competencies set out in ARONAH's Competency Standards for Western herbalists.

The qualifications for entry to practice as a WHM practitioner would generally be at AQF Level 7 or equivalent with provision for grandparenting of practitioners with historic qualifications who can demonstrate a record of safe practice.

In this report, WHM practitioners are also referred to as 'herbalists'.[3]

Consumer expectations and use of naturopathy and WHM

Chapter 2 presents the results of a systematic review of the published empirical research on the characteristics and experiences of consumers who use the services of naturopaths and herbalists in Australia.

The review synthesises the available research literature published since 2005, to understand the consumer demographics, motivations and reasons for use, the consumer experience of naturopathic and herbal medicine care, and prevalence, that is, the proportion of the population who use the services of naturopaths and herbalists.

Four databases were searched, and 478 records identified, of which 31 were included in the study.

The findings, when combined with earlier findings from the Lin Report (2005) tell a story that has remained largely consistent over the last 30 years:

- A sizeable segment of the Australian population (at least 7%) chooses to use the services of a naturopath or herbalist to maintain their health, prevent illness, and treat acute and chronic health conditions.
- These health consumers tend to be active in seeking health information and are choosing to use the services of a naturopath or herbalist to treat a wide range of chronic illnesses that involve every bodily system, as well as to maintain wellbeing, and for preventive health.
- Consistent with earlier findings (Lin et al., 2005: 250), those who use the services of a naturopath or herbalist are more likely to be female and, on average, are more highly educated than the general population.
- Studies show comparatively higher than average use of naturopaths and herbalists by specific groups, such as middle-aged women, pregnant women, recent new mothers and women trying to conceive, women with various chronic conditions such as endometriosis and PMS, and cancer patients and survivors.
- Consumers are consulting naturopaths and herbalists for a range of chronic conditions such as diabetes, cancer, cardiovascular disease, respiratory illness, female reproductive conditions, and mental illness, as well as musculoskeletal conditions, gastrointestinal issues, back pain, menstrual or menopause symptoms, and for pregnancy-related care.
- Consumers are consulting with a naturopath or herbalist for long-term conditions, as preventative health care, and to enhance the effectiveness of other medical treatments and medications.
- The satisfaction of consumers with the services they receive from their naturopath or herbalist is consistently very high. Consumers report perceiving their naturopath or herbalist as supportive and compassionate, the health care type as safe, and offering a sense of control over their health.
- Consumers commonly use naturopathy or WHM concurrently with biomedicine (including pharmaceutical drugs) and they often do not inform their GPs or their naturopaths or herbalists about this concurrent use.

The researchers conclude:

- Navigating between two systems of medicine (naturopathy and biomedicine) carries heightened risks for consumers, particularly if they feel they

2 Noting there is not yet broad consensus among professional associations and education providers concerning Australian competency standards for naturopaths, this report references the Australian *Competency Standards for Naturopathic Practitioners*, published by ARONAH. See ARONAH website: www.aronah.org/wp-content/uploads/ARONAH_Competency-standards_Naturopaths.pdf

3 Noting there is not yet broad consensus among professional associations and education providers concerning Australian competency standards for Western herbalists, this report references the Australian *Competency Standards for Western Herbalists*, published by ARONAH. See ARONAH website: www.aronah.org/wp-content/uploads/ARONAH_Competency-standards_Herbalists.pdf

cannot (or choose not to) inform the practitioners involved in their care about their use of particular services and medicines.

- Given the potential interactions between herbal medicines and pharmaceutical drugs, there are ongoing concerns about the reported lack of communication between biomedicine practitioners (notably GPs and medical specialists) and naturopaths or herbalists.
- Given that consumers are continuing to choose naturopathy and WHM, rather than ignoring this segment of the health workforce, it is incumbent on governments to develop specific policies that address issues concerning the safety and quality of these practitioners and the services they provide.

Risks associated with the practice of naturopathy and WHM

Chapter 3 documents and analyses evidence of the risks and harms associated with the practice of naturopathy and WHM in Australia. The chapter:

- presents an overview of the main risks associated with the practice of naturopaths and herbalists
- provides a bibliometric analysis of the scientific literature on adverse events associated with the consumption of nutritional and herbal medicines
- summarises the results of landmark studies of risks and compares the risk profile of naturopaths and herbalists with those of the registered health professions
- presents and analyses data gathered from health complaints entities (HCEs) and professional associations, highlighting the gaps and deficiencies in this data, and
- documents cases from the media, and court and tribunal reports on complaints about naturopaths and herbalists (or those purporting to be a naturopath or herbalist), and how these have been dealt with.

Key findings include:

- Naturopaths and herbalists have a broad scope of practice – they practise in the area of 'general medicine', treating patients with a wide range of illnesses and conditions, often of a chronic and serious nature.
- The scope of practice of naturopaths and herbalists includes a comparatively large number of high-risk activities, when compared with most of the health professions regulated under the NRAS;
- Risks arise from the treatment modalities or therapies used (prescribing and supply of naturopathic medicines and nutritional supplements), the exercise of clinical judgement, the scope of practice and the context of practice.
- There has been an exponential rise in the reporting of adverse events associated with the use of herbal medicines and nutritional supplements, with no evidence of progress by regulators in over 20 years to document and publish data on the scale and nature of the problem, to enable preventive action to be taken.
- The annual number of complaints about naturopaths, herbalists and other natural therapists dealt with by HCEs and professional associations has risen substantially over the past 20 years, with complaints about professional conduct accounting for almost half of all complaints.
- While the risk of harm to patients can be mitigated by proper training of practitioners, there continues to be no mechanism to enforce minimum education standards for entry to practice as a naturopath or herbalist.
- Consistent with previous findings, persons who misrepresent themselves to the public as qualified to practise naturopathy, using the titles 'naturopath' or 'herbalist' without qualifications, continue to feature prominently in the complaints data.
- Deaths and serious injuries associated with unqualified or under qualified practitioners occur from time to time and professional associations have few avenues available to address these risks because such persons often do not join professional associations. While professional associations have taken steps to warn the public, and in some of the most egregious cases, HCEs have issued prohibition orders to remove these people from practice, these cases are continuing to occur.

The researchers conclude that these findings – the degree of risk and the evidence of the pattern of harms documented here, require the attention of governments and warrant stronger regulation of these professions.

The benefits of naturopathy and WHM

Chapter 4 provides an overview of the scientific literature on the health outcomes associated with naturopathic and WHM clinical practice. To undertake a comprehensive review of the scientific literature on the impacts and benefits of naturopathy and naturopathic practice would generate thousands of references and require resources that are beyond the capacity of this study. Instead, two pieces of research were undertaken.

First, a bibliometric analysis of citations in the published literature concerning the 'tools of trade' of naturopaths and herbalists (herbal medicines and nutritional supplements) was undertaken, to illustrate the scope and scale of the scientific literature on naturopathy and WHM.

Second, a critical review was undertaken of five landmark studies that have documented evidence of the effectiveness of naturopathy and WHM, to weigh the evidence presented and draw conclusions about the body of knowledge on the benefits of naturopathy and WHM.

Key findings include:

- The research reported in the Lin Report (2005), the systematic review (Oberg et al., 2015), the scoping review (Myers et al., 2019) and the WNF Naturopathic Medicine Health Technology Assessment (Lloyd et al., 2021) present a consistent picture – that there is a substantial body of evidence that demonstrates the effectiveness of naturopathy and WHM as health practices. This literature encompasses both the tools of trade of naturopathy (herbal medicines and nutritional supplements) and naturopathy as a system of medicine.
- However, a contrary conclusion was reached in the Federal Government's Natural Therapies Review of 2015 and on the basis of its findings, the Federal Government decided to remove private health insurance rebates for patients of naturopaths and herbalists.
- While the Federal Department of Health subsequently accepted that there were limitations in its 2015 review and commissioned a second review, the decision taken to withdraw private health insurance rebates remains in place. The effect has been to remove an important mechanism for assuring the quality and safety of the naturopathy and WHM workforce, penalise naturopaths and herbalists and prevent many Australians from accessing these therapies using their Private Health Insurance.
- At the time of writing, the second Federal Government review report on the evidence evaluation of naturopathy is yet to be published. However, the submitted evidence on WHM and naturopathy is available on the Department of Health's website. Presented are over 670 studies on WHM and over 440 studies on naturopathy. While this evidence is still being evaluated by the National Health and Medical Research Council (NHMRC), it provides a substantial body of literature on the effects of naturopathy and WHM and their key therapies and practices.

The researchers conclude that:

- Assessments aimed at determining the scientific effectiveness of a therapy need to be conducted in a methodologically robust, fair and unbiased way, considering both the evidence of effectiveness as a clinical practice (the clinical audit literature) and the literature of the effectiveness of the professions' 'tools of trade'.
- For reasons set out in Chapter 4, the methodology adopted by the 2015 Natural Therapies Review was flawed and therefore its conclusions were not well-founded. Despite this flawed process, policy decisions taken by the Federal Government based on the review's conclusions have had adverse consequences for the professions of naturopathy and WHM.
- Taken together, the studies described in Chapter 4 provide a substantial body of scientific literature on which it is reasonable to conclude that naturopathy and WHM are effective systems of health care, with demonstrated benefits for a wide range of conditions and across all major body systems.

The naturopathy and Western herbal medicine workforce

Chapter 5 presents the results of a systematic review of the empirical evidence published since 2005 concerning the characteristics of the naturopathy and WHM workforce in Australia. This includes the demographic features of the workforce, the nature of naturopathic practice, the profile of patients who use naturopathic services, and the professional and interprofessional practice issues reported by naturopaths and herbalists.

Key findings include:

- Naturopaths and herbalists in Australia have a broad scope of practice, providing primary care to diverse populations with diverse health needs. They treat patients with a variety of health conditions, using ingestive medicines such as herbal medicines. In some rural areas, the evidence suggests naturopaths represent up to one third of primary care practitioners.
- The majority of naturopaths and herbalists are female and aged under 60 years. They work principally in solo private practice where, in comparison with group and multi-disciplinary practices, systems of clinical governance are likely to be weak or non-existent.
- Naturopaths engage with their patients in a range of areas important for maintaining health including diet and nutrition, mental health, substance use and, in some instances, vaccination. This important role in primary care means that provision of any inaccurate or misleading information has the potential to undermine important public health messaging and present significant risks to the community.
- While naturopathy is a multi-modality practice with practitioners employing an eclectic range of therapies and practices, naturopaths frequently prescribe ingestive medicines in their practice, most commonly herbal medicines and nutritional supplements.

- While some practitioners practise as herbalists, solely using WHM, the practice of WHM is core to the practice of naturopathy. Survey data suggests that over one third of naturopaths hold qualifications in WHM, almost all naturopaths prescribe herbal medicine products, and naturopaths spend a greater proportion of their time practising herbal medicine than any of the other types of therapies.
- Degree level training is considered by a majority of the profession to be the minimum qualification required for safe and competent practice of the naturopathy & WHM professions. While degree programs have been available in Australia for over 20 years, the data suggests that between 2011 and 2020, the proportion of naturopaths with advanced diploma qualifications increased from one-third to almost half of the profession.

The researchers conclude:

- It is imperative that naturopaths and herbalists are properly trained to work as primary care clinicians and are well integrated within the broader primary care and public health systems.
- Given scope and context of practice of naturopaths and herbalists that includes use of ingestive therapies as a principal modality, and the range of associated risks, degree level training is considered the minimum level necessary to ensure safe and competent practice.

Education of naturopaths and herbalists for entry to practice

Chapter 6 presents the results of a survey of Australian naturopathy and WHM education providers undertaken in June-July 2021. It provides a profile of education providers and the programs of study available for entry to practice and postgraduate studies in naturopathy and WHM. Key changes in the sector since 2005 are discussed, along with issues confronting the profession with respect to education.

Key findings include:

- There are five known education providers of naturopathic and WHM programs in Australia – two in the university sector and three private providers.
- The programs offered by the two universities and one private provider are accredited under arrangements administered by the responsible Federal Government education authority – the Tertiary Education Quality and Standards Agency (TEQSA). These educational institutions have governance arrangements that include academic councils, boards, and/or committees to oversee the content and conduct of programs. The two remaining private provider programs are not accredited by any government education authority.
- The quality of education varies markedly between degree and diploma level programs, particularly with respect to student contact hours and arrangements for clinical training.
- Providers of degree and diploma programs hold opposing views regarding the minimum educational requirements for entry to practice as a naturopath or herbalist, the type of regulation required for the profession and the future of these professions.
- Four out of five national professional associations that represent naturopaths and herbalists have set bachelor's degree level naturopathic or WHM qualifications as the minimum required for practitioner membership. However, one professional association, the Australian Traditional Medicine Association (ATMS), and more recently, several educational institutions continue to support reverting to an advanced diploma qualification as the minimum qualification for entry to practice as a naturopath or herbalist.
- In 2005, Lin & colleagues made a series of recommendations to strengthen education of the naturopathy & WHM professions, including that the professions work towards a bachelor's degree as the minimum requirement for entry to practice. In the 20 years since, none of these recommendations have been implemented.

The researchers conclude:

- This division within the profession over minimum entry to practice education standards is now a four-decade-old struggle, one that is unlikely to be resolved without government intervention.
- Despite some progress in establishing education standards (via ARONAH's competency and program accreditation standards), there remains no unified national standard for the minimum qualifications required for entry into these professions. This variability leads to inconsistencies in practitioner competence and has flow on effects both for public confidence in the professions and for public safety.
- The continued availability of unaccredited advanced diploma training for entry to practice is of concern and can be attributed to two factors: the lack of a mechanism for enforcing degree level as the minimum qualification for entry to practice and the fragmented nature of representative arrangements that enable and reinforce multiple entry level qualification standards.
- Establishing and enforcing a national standard for education of naturopaths and herbalists would ensure that all practitioners meet a minimum level of competence, thereby improving the quality of care provided to the public and reducing the risks of harm outlined in Chapter 3.

Professional representative arrangements for naturopaths and herbalists

Chapter 7 presents the results of a survey of organisations that represent and/or regulate naturopaths and herbalists in Australia, undertaken in June-July 2021. Survey data was supplemented by searches of publicly available information posted on the websites of professional associations, including for those associations that did not respond to the invitation to participate in the survey. Using both data sources, this chapter presents key features of the professional associations that represent naturopaths and herbalists, including their membership profiles, codes, and guidelines issued, standards, policies and procedures, and views about regulation and other issues of importance to the professions.

Six organisations met the survey inclusion criteria and were invited to participate. Of these, three organisations provided survey data: Complementary Medicine Association (CMA), Naturopaths and Herbalists Association of Australia (NHAA), and the Australian Register of Naturopaths and Herbalists (ARONAH).

Key findings include:

- There has been some consolidation of the representative arrangements for the naturopathy and WHM professions – of the 17 professional associations reported by Lin & colleagues in 2005, only five of these associations are still in operation twenty years later.
- The roles and functions of these representative organisations are typical of professional associations generally – the setting of education and practice standards for members, credentialling of practitioners, assessment and accreditation of programs of study, dealing with complaints about members, protecting and advocating on behalf of the professions, and protecting the public (through self-regulation).
- As reported in 2005, the absence of effective government regulation has allowed education and practice standards to evolve in an ad hoc manner, overseen by multiple associations with various positions regarding regulation.
- An important initiative has been the establishment of a voluntary register (ARONAH) that operates at arms-length from professional associations and whose primary purpose is to protect the public rather than to represent the interests of the naturopathy and WHM professions. However, ARONAH's role in setting standards in the public interest is not well understood or communicated. The lack of government incentives for naturopaths and herbalists to join the ARONAH register limits its effectiveness and recognition among practitioners and the public.
- The continued fragmentation of representative arrangements, the number of associations, and the disagreements on entry to practice qualifications, education, and occupational regulation are compromising the ability of these organisations to discharge core functions on behalf of the professions.
- Governance practices among associations show wide variation. Only one organisation consistently publishes its annual reports and strategic plans, documents that are critical for transparency and accountability. The lack of published governance documents from most associations contributes to a perception of opacity and reduces the professions' credibility. Improving governance practices and enhancing transparency would build trust and ensure that associations are accountable to their members and to the public.
- Because members and resources are spread across multiple associations, the capacity of every association to deliver a full range of benefits to members and engage in advocacy efforts on behalf of the professions is compromised.
- Complaints are an important source of data for quality improvement. However, there is little transparency in the complaints management processes of most organisations, and little evidence that members of the public are being encouraged or assisted to lodge complaints or that disciplinary processes are well managed.
- Most websites are light on content that would suggest strong and active policy/guidance and advocacy functions. Some associations lack clear and accessible information for their members and the public on policy issues and health guidelines, resulting in missed opportunities for professional advocacy and public education. Effective advocacy is essential for influencing policy and improving public health outcomes. A more coordinated and proactive approach to advocacy would ensure that the profession's voice is heard in important health policy debates and that members are well-informed about relevant issues.

The researchers conclude:

- The naturopathy and WHM professions are characterised by significant fragmentation, with numerous associations operating independently and in competition with each other. Such fragmentation leads to diluted resources, inconsistent standards, and a lack of a unified voice for the professions. This undermines the cohesion and collective strength of the professions that are necessary for effective self-regulation and public trust. The lack of a singular, cohesive professional body hinders the ability to advocate effectively for the professions and creates confusion among practitioners and the public.

- It is difficult for self-regulation to be effective, transparent, and accountable while the regulators are not independent of the professional associations and educators (Commonwealth Government Expert Committee 2000). While the establishment of ARONAH has gone some way to providing a self-regulatory framework that is independent of the professional representative functions, it is hampered by lack of resourcing due to its small membership base and lack of government incentives to encourage naturopaths and herbalists to join.
- It is imperative that associations strengthen their management of complaints and discipline, particularly to develop stronger links with health complaints commissioners in each state and territory, provide more consumer-friendly information on the code of conduct and prohibition order powers that apply in six jurisdictions and provide a consistent data set on complaints management, to enable better monitoring of risks and harms associated with naturopathy and WHM practice.
- As in 2005, the solution remains consolidation – fewer, larger, better-resourced associations would benefit these professions and better protect the public.

Institutional recognition of and support for naturopathy and WHM practice

Chapter 8 documents and analyses the broader institutional arrangements within which naturopaths and herbalists operate. The focus is to identify the extent to which the institutions of government and civil society recognise and/or engage with naturopaths and herbalists and influence or shape their practice.

Presented are the findings of enquiries made of a variety of institutions both government and non-government, including public and private health fund providers, professional indemnity insurers, regulators, health services, research institutions, and professional associations.

Key findings include:

- No specific references were found to the eligibility for reimbursement of services provided by naturopaths and herbalists in any third-party compensation schemes, either public (Medicare, PBS, Veterans, Workers Compensation, Traffic Accident) or private (private health insurers). The only exception was the workers compensation scheme in Victoria.
- Most mainstream institutions that represent practitioners, hospitals, health services, and professional associations do not have formal positions or policies with respect to engaging with naturopaths or herbalists, or even recognising that consumers are using these health services in conjunction with biomedicine. If there are stated positions, these relate to complementary medicine in general rather than specifically to naturopaths and herbalists.
- In most of the materials found, a commonly expressed view is that complementary medicine practices and professions either are not evidence-based or the scientific evidence is deficient.
- Some developments are evident in the area of research capability – with the establishment of several dedicated research institutes (at Southern Cross University, University of Technology Sydney and Western Sydney University). However, in general, the profession has lost important institutional status and benefits with the loss of private health insurance rebates and government accreditation of programs of study for entry to practice as a naturopath or herbalist.

The researchers conclude:

- In the last 20 years, some unregistered allied health professions have achieved substantial institutional recognition and benefits in the absence of statutory registration under NRAS; for example, exercise physiologists, dietitians and speech pathologists are all eligible providers under various Medicare programs. However, such professions do not face the same attitudinal hurdles that naturopaths and herbalists face by virtue of categorisation as 'complementary medicine' professions.
- The widespread but inaccurate view that naturopathic and WHM practice are not 'scientific' or 'evidence based' appears to present a significant barrier for mainstream institutions to accept, recognise, or engage with naturopaths and herbalists as they deliver primary and preventive health care to the Australian population.
- While these professions appear to have made some progress in research capability, the naturopathy and WHM professions have lost institutional status and benefits with the removal of private health insurance rebates for complementary therapies in 2018 and the loss of government accreditation of education programs for entry to practice as a naturopath or herbalist.
- It appears the registered complementary medicine professions have been protected from these changes and that it appears easier to achieve recognition and benefits, or at least to protect such benefits when a profession is regulated under the NRAS. While there are some other unregistered allied health professions that have achieved institutional recognition and benefits without statutory registration under NRAS (for example, exercise physiologists), such professions do not face the attitudinal barriers that naturopaths and herbalists face by virtue of their categorisation as 'T&CM' professions.

Regulation of the naturopathy and WHM professions

Chapter 9 documents and analyses the framework of laws that apply to and shape the practice of naturopaths and herbalists in Australia, including the laws that regulate the use of herbs and nutritional medicines.

The main types of occupational regulation are described, and their key features are compared. The extent to which these types of occupational regulation apply to the naturopathy and WHM professions in Australia is discussed. International developments in occupational regulation of naturopaths are summarised, with particular reference to those trends and developments relevant to occupational regulation of the Australian naturopathic and WHM professions. Considering the risks of naturopathy and WHM practice and the institutional context of practice, some gaps in regulation are identified.

Key findings include:

- Many governments have recognised the need to support patient choice by strengthening regulation of naturopaths, and many jurisdictions have introduced statutory registration for the profession – see the WNF Health Technology Assessment (Lloyd et al., 2021). Once a leader in regulation of complementary therapies, Australia is now lagging.
- It is 20 years since the Lin Report identified the need for governments to put in place effective patient protection measures, to better protect the substantial portion of the population who use the services of a naturopath or herbalist. Since then, government policy changes, particularly at the federal level (in accreditation of education and private health insurance rules), have undermined and compromised the professions' efforts to self-regulate, to the detriment of health consumers.
- While the occupational regulation arrangements, which rely principally on self-regulation and negative licensing, go some way to protecting the public, these quality assurance mechanisms are inadequate, given the pattern of harms documented in this report (see Chapter 3).
- For instance, the COVID-19 pandemic has drawn attention to cases where untrained or poorly trained naturopaths have acted in ways that undermine public health messaging about infection control and vaccination. There is a need for governments to engage with naturopathy professional bodies to reinforce good practice standards and develop public health messaging, to ensure accurate information is provided to patients.

The researchers conclude:

- Patients have the right to choose naturopathic care and in doing so, should not be exposed to unnecessary risks because governments have removed the co-regulatory mechanisms that were working to promote quality of care and keep them safe.
- Failure to include naturopaths and herbalists and their representative bodies in mainstream service provider networks and government consultations, as occurred during the COVID-19 pandemic and is continuing to occur, is not tenable or in the public interest.
- Failure to develop explicit policies concerning this workforce is contrary to WHO policy on traditional and complementary medicine (WHO 2013). As a matter of priority, state, territory and federal governments should:
  - re-visit the policy changes that have undermined self-regulation of naturopaths and herbalists, and
  - re-examine the case for statutory registration.

REGULATORY ASSESSMENT

Chapter 10 concludes with an assessment of the naturopathy and WHM professions against the criteria for assessing professions for inclusion in the NRAS that are set out in the AHMAC Guidance of 2018.

Criterion 1 – Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation fall more appropriately within the domain of another Ministry?

Responsibility for determining regulatory policy concerning occupational regulation of the professions of naturopathy and WHM properly sits within the health portfolios of state, territory, and federal Health Ministers.

There are no other ministerial portfolios at either state/territory or federal level that have responsibility for regulation of naturopaths and herbalists.

Naturopathy and WHM are 'health professions' that provide 'health services':

- the services provided by naturopaths and herbalists fall within the statutory definition of a 'health service' contained in health complaints legislation in each state and territory
- consumer complaints about naturopaths and herbalists fall within the jurisdiction of health complaints commissioners in each state and territory
- the tools of trade of naturopaths and herbalists (herbal medicines) are regulated by the Therapeutic Goods Administration under the Australian Government Department of Health and Ageing.

Conclusion regarding Criterion 1:

It is **appropriate for Health Ministers to exercise responsibility** for determining the regulatory arrangements for naturopaths and herbalists and regulating naturopathic/WHM practice. Naturopathy and WHM are health professions that sit within the health portfolio. Regulatory policy for these professions does not belong within another sector or Ministry.

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

Naturopaths and herbalists are primary care practitioners who work autonomously, principally in solo or group private practices (Steel et al., 2020). The practise of naturopathy and WHM is broad in scope and presents a range of risks of varying significance. The literature provides extensive references on these risks (Lloyd et al., 2021; Weir, 2016; Lin et al., 2005).

The risks can be categorised as follows:

- risks associated with the treatments used by naturopaths and herbalists
- risks associated with the scope of practice of naturopaths and herbalists
- risks associated with the practice context

These risks are not just theoretical – there are documented case examples where these risks have been realised in practice in Australia – see Chapter 3 of this report.

Risks associated with treatment modalities used by naturopaths and herbalists

Risks associated with the treatment modalities used by naturopaths and herbalists fall into two categories:

- risks associated with the exercise of clinical judgement by the naturopath or herbalist
- risks that arise from the consumption by patients of nutritional and herbal medicines

Cases of adverse events related to acts of commission (such as recommending cessation of medical treatment or failure to avoid known interactions with pharmaceuticals) and acts of omission (such as misdiagnosis and failure to refer on to an appropriate practitioner) have been reported in the literature and in the media. Although these events do not appear to be widespread, the COVID-19 pandemic has highlighted further cases and the potentially serious consequences.

Like conventional pharmaceutical medicines, herbal medicines can produce predictable and unpredictable effects. Examples of both have been identified in the literature. Predictable effects include direct toxicity, toxicity related to overdose of a preparation, and interaction with pharmaceutical medicines. Unpredictable effects include allergic and anaphylactic reactions to herbal medicines, and idiosyncratic reactions (Colalto 2012; WHO 2004).

Several herbs and supplements are known to cause toxic reactions and while severely toxic substances are restricted by current drugs and poisons legislation, several potentially toxic substances continue to be available to naturopaths for use in prescriptions (Asif 2012; Brown 2017; Brown 2018; Posadzki et al., 2013).

Herbal medicines have the potential to interact with pharmaceutical drugs (Gurley et al., 2012), and numerous cases of such herb-drug interactions have been reported (Myers & Cheras 2004; Izzo & Ernst 2009).

The risk profile of the naturopathy and WHM professions is increasing due to factors such as:

- the use of naturopathic/herbal medicines for a wider range of illnesses.
- concurrent use of pharmaceutical medicines along with herbal medicines and nutritional supplements (Morgan et al., 2012)
- the development of manufacturing techniques that alter the potency of products
- the accessibility of products from overseas suppliers with unknown manufacturing standards and product authentication processes (2005: 46-7, 292)

Risks associated with the scope of practice of naturopaths and herbalists

Naturopaths and herbalists are primary care practitioners who provide diagnostic and treatment services under a paradigm that differs from that of conventional biomedicine. They have a very broad scope of practice – they see patients from every demographic and treat a wide range of health conditions, including patients with potentially life-threatening illnesses. They do this without the need for a referral from a medical practitioner.

Health practitioners with similarly broad scopes of practice, such as medical practitioners, nurses and Chinese medicine practitioners are all subject to statutory registration under the NRAS.

Applying the risk assessment framework used by governments to assess the need for occupational regulation of health professions, the scopes of practice for naturopaths and herbalists typically include at least eight (8) out of the 13 identified high risk activities. This is high compared with most other registered health professions, where the range is between three high risk activities (for optometrists, pharmacists, and psychologists) and 13 (for medical practitioners). Only five regulated professions have a higher risk rating than naturopaths and herbalists. They are medical practice (13), nursing and midwifery (10), paramedicine (10) and Chinese medicine (10).

Every naturopath and herbalist has a professional obligation to recognise the limits of their practice and to refer on to other practitioners, including medical practitioners, when the needs of the patient dictate. This is an important part of their ethical and clinical training.

Harms occur when a naturopath or herbalist fails in their exercise of clinical judgement, either through acts of commission or omission. These risks relate to incorrect, inadequate, or delayed diagnosis, or failure to make timely referrals to practitioners who are best placed to treat the patient. These risks increase when the naturopath or herbalist has received insufficient clinical and ethical training to recognise the limits of their practice and make appropriate referrals.

Table 3.5 includes a selection of high-profile cases where naturopaths and herbalists have been prosecuted for offences ranging from sexual assault to making false or dubious treatment claims, misrepresenting their qualifications and advising their patients to cease conventional medical treatments. These are all very serious matters. Many of these cases involve individuals who have had insufficient training and would not be eligible to practise naturopathy or WHM if minimum entry level qualification and probity standards were enforced.

Risks associated with the practice context

Other contextual factors add to the risks associated with naturopathic or WHM practice, compared with the regulated health professions, including:

- the absence of effective controls over entry to practice as a naturopath or herbalist
- the difficulties for patients in identifying who is properly qualified and in good standing as a naturopath or herbalist
- the challenges for patients of navigating two systems of medicine, particularly for those who use naturopathy or WHM in conjunction with pharmaceutical medicines
- the absence of quality controls exercised through employers, public sector work settings, and third-party payment systems (health insurers)

These are elaborated on below.

First, with the lack of effective controls over entry-to-practise as a naturopath or herbalist, any person can set up practice without qualifications or probity checking. There is no enforced minimum entry level qualification, no minimum standard of education necessary for clinical practise as a naturopath or herbalist, and no checking to ensure the person is of good character prior to their commencing practice.

This heightens the risk to patients, particularly in light of risks described earlier – that naturopaths and herbalists have a very broad scope of practice, they treat patients with a wide range of health conditions, using treatment modalities that carry inherent risks. Also:

- naturopaths and herbalists do not have access to the range of diagnostic tools that are available to practitioners of conventional medicine
- untrained or undertrained persons are less likely to recognise the limits of their skills and knowledge and to refer on appropriately
- misdiagnosis is more likely if clinical training hours are inadequate or there is inadequate exposure during training to a range of patients and health conditions
- there is a lack of training and guidelines on the clinical management of patients who use naturopathic/herbal medicines in conjunction with pharmaceutical drugs

The data presented in Chapter 3 shows a pattern of harms associated with those who seize the opportunity to 'make a quick buck', choosing to flout professional norms by establishing themselves in practice without industry recognised qualifications. Anecdotal evidence suggests such practitioners are more likely to disregard other ethical norms and standards of professional practice. Recent cases demonstrate this problem – unqualified persons who pretend to be qualified have used the opportunities presented by their practice as a naturopath or herbalist to breach the trust of their patients by committing sexual assault (see Table 3.5).

The media coverage of these cases reports these people as 'naturopaths', because that is the title they have assumed for themselves. However, the reality is that most are not qualified naturopaths – they may have done short courses, may have no qualifications at all, or have been deregistered from a health profession regulated under the NRAS. They have traded on the reputation of and trust in the naturopathy and WHM professions to exploit vulnerable patients.

Second, compounding these problems, there is no single trusted source of information for prospective patients about who is qualified as a naturopath or herbalist and in good standing in their profession. Instead, there are multiple and competing professional associations, all of which claim to represent qualified naturopaths and herbalists but set different qualification standards for membership and provide different levels of service to members and to the public. This adds to the confusion for prospective patients.

This multitude of professional bodies with their varying standards exacerbates the information asymmetry so that the average consumer is likely to struggle to know who is properly qualified as a naturopath or herbalist and who is not.

Third, unlike many of the allied health professions:

- most naturopaths and herbalists are self-employed and work in independent private practice rather than for large employers (Steel et al., 2020)
- naturopaths and herbalists are not generally employed in the publicly funded health services where governments have a role in setting standards, via funding arrangements and/or policy directions
- the services provided by naturopaths and herbalists are not reimbursable under Australia's universal health insurance scheme or by other third-party payers such as for veteran's health services, workers compensation, and traffic accident schemes
- the services pwvided by naturopaths and herbalists have not been reimbursable by private health insurance funds since this entitlement was removed in 2019[4]

The quality controls that usually apply in group settings (employment contracts, clinical governance systems, risk audit, performance appraisal etc) are absent. Also, with the removal of naturopathy and WHM services from the eligibility for rebates under the Australian Government's *Private Health Insurance Rules*, there are no institutional quality control measures applied by third-party payers, that is, no public and private health insurers who scrutinise claims data and may alert regulators to professional practice or clinical governance failures.

Fourth, for those who use both naturopathy or WHM and biomedicine, there are heightened risks associated with herb/drug interactions. These risks are exacerbated by a general lack of communication among the various providers and the lack of training and guidance for practitioners on the clinical management of patients who use naturopathic and other herbal medicines in conjunction with pharmaceutical drugs. As more people with chronic health conditions choose naturopathic or WHM treatment, the potential for herb/drug interactions increases. Compounding this problem, there is evidence that many patients do not tell their treating medical practitioners of their use of naturopathic/herbal medicines.

Those who enter practice with inadequate or no qualifications and clinical training are less likely to have the capacity or motivation to keep up to date with the exponential growth in naturopathic/WHM research, they are less likely to be engaged with their peers in scholarly collaboration, or to adopt evidence-based naturopathic/WHM practice.

Conclusion regarding Criterion 2:

The treatment modalities, scope of practice, and practice context of naturopaths and herbalists all contribute to a risk profile that is **unacceptably high** and on par with or greater than many of the health professions that are subject to statutory registration. These risks are not just theoretical – the data shows there is a pattern of harm, with repeated cases over three decades.

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

Naturopaths and herbalists are subject to a range of laws and regulations at federal, state and local government levels (see Chapter 9). Taken together, these laws present a complex and confusing array of mechanisms for assuring the quality of naturopathic services and protecting public health and safety. While responsibilities are shared across a range of regulators, there are significant gaps and deficiencies. Unlike the NRAS for the registered health professions, there is no single regulator that has sufficient powers to effectively mitigate these risks.

The failures are in four areas:

- failure of self-regulation
- failure of co-regulation
- limitations of negative licensing (code regulation)
- lack of access for naturopaths to some of their tools of trade

Failure of self-regulation

Self-regulation describes the various certification schemes operated by member based professional associations. Effective certification schemes are operating for many unregistered allied health professions – see for example Speech Pathology Australia, the Dietitians Australia, and the Australian Association of Social Workers (AASW). However, the politics at play mean the naturopathy and WHM professions are ultimately incapable of achieving the unified institutional representation that is needed to achieve effective self-regulation, to the detriment of patients.

4 See Natural Therapies Review.

Given the risk profiles of naturopathy and WHM professions (see Criterion 2), relying on self-regulation to protect the public from harm has proved to be inadequate (see **Chapters 3 & 10**) when the practices of a health profession present potentially serious risks to public health and safety.

If it were simply a matter of the profession redoubling its efforts, then it would be reasonable for governments to expect more from the profession. However, it is wrong to assume that these failures result from of lack of capability or effort on the part of the profession. Instead, they reflect broader institutional failures associated with the power dynamics at play within and beyond the profession – a lack of authoritative guidance, support, and recognition from governments and other institutions such as insurers and employers:

- Where there are no statutory powers to restrict entry to a profession and no co-regulatory incentives applied by governments, those with minimal or no qualifications can set up practice and use the titles of the profession without meeting acceptable minimum standards of training and practice. This has led to widely varying standards of practice and levels of qualifications, substantial fragmentation of these professions, and no widely recognised and accepted peak bodies (Lloyd et al., 2021: 50).
- Most professional associations rely on volunteers drawn from the profession who may lack access to the necessary skills, resources, and capacity to handle the complexity associated with effective regulation (Lloyd et al., 2021: 50).
- There are conflicts of interest in the operation of voluntary certification, which can compromise public protection, for example, where the professional association is responsible for representing its members' interests while also maintain educational standards by accrediting education programs and dealing with complaints about members.
- Schemes that operate at arms-length from professional associations (such as the model adopted in Australia by ARONAH) are often constrained by poor resourcing and lack of policy capacity and as with all voluntary certification, the standards apply only to those practitioners who choose to opt in (Lloyd et al., 2021: 50).

Reliance on professional associations to effectively manage complaints about members is problematic. Successive studies have found:

- Unlike complaints and disciplinary systems operated by statutory bodies, there is little transparency or accountability and little published information about the procedures followed or the outcomes achieved (see **Chapter 6**).
- Those managing the disciplinary processes often lack experience in the principles of natural justice and procedural fairness (2005: 297).
- These complaint management systems have limited or no avenues of appeal and, most importantly, lack teeth – naturopaths who are the subject of investigation have been known to let their membership lapse to avoid disciplinary action.

Many of the more egregious cases described in **Table 3.5** appear as isolated individual failures. However, they reflect a pattern of harms linked to a broader institutional failure that has been confronting the naturopathic and WHM professions for decades.

In response, the profession has made considerable efforts to 'get its house in order' (Dean et al, 2002; Lin et al., 2005: 296). However, successive attempts at profession-led self-regulation, over almost three decades, largely have been ineffective. Efforts have been hampered by the fragmented representative arrangements, the ongoing disagreement amongst professional associations about the entry level qualifications required for safe and competent practice, and lack of government leadership and support. The lack of agreement on entry to practice qualifications is an important contributing factor in the continuing fragmentation of representative arrangements within the profession.

Similar challenges were faced by the Chinese medicine profession in the 1990s in its efforts to self-regulate. The profession faced a substantial and increasing risk profile, fragmented professional representation, inability to achieve broad consensus within the profession on minimum standards of training for entry to practice (despite successive efforts), and lack of broader institutional reinforcement of self-regulation (Victorian Government, Department of Human Services, 1998). In that case the Victorian Government recognised the need to intervene in the public interest and legislated to establish the first registration scheme for the Chinese medicine profession in Australia (Carlton 2017: 186-202).

Failure of co-regulation

Governments play an important role in reinforcing and supporting professional association led voluntary certification schemes, principally by providing incentives that encourage practitioners to participate in and comply with voluntary certification requirements.

For instance, by tying access to recognised provider status under various government health insurance schemes (Medicare, Veterans Health, traffic accident, and workers compensation) with participation in a professional association led certification scheme, governments have established powerful incentives for allied health practitioners to join such certification schemes and comply with the standards set. Other examples of such co-regulation arrangements include:

- the Australian Government's Private Health Insurance Rules[5] which determine what types of health services are eligible for patient rebates paid by private health insurers
- the Australian Government Department of Home Affairs (Immigration and Citizenship) recognition of some allied health professional associations as assessing authorities for the purpose of assessing the qualifications of applicants for skilled migration.[6]

However, unlike in the UK[7] where a health sector wide co-regulatory scheme has been established to quality assure the unregulated health professions, Australian governments have missed several important opportunities to use the levers of co-regulation to require or reinforce unified national qualification and practice standards for the naturopathy and WHM professions.

Australian governments provide few incentives for naturopaths and herbalists to submit to voluntary certification with a peak professional association. To complicate matters, governments recognise the standards of multiple associations, thereby undermining any efforts to achieve uniform national standards. Since publication of the Lin Report, several opportunities have been missed for governments to implement a common minimum qualification standard for entry to practice. In fact, standards have deteriorated with the Federal Government's withdrawal of two important mechanisms previously relied upon by professional associations to set and reinforce minimum qualification and practice standards for naturopaths:

- the removal in 2019 of eligibility of naturopaths and herbalists for provider rebate status with private health funds, and
- the withdrawal in 2016 of the VET sector accreditations of naturopathic and WHM qualifications and training providers

Recognition of multiple professional associations means that a practitioner found to have breached the standards of one association can join another association that has national standards and maintain their GST-free status as a 'recognised professional'. The effect of these changes has been to undermine efforts by professional associations to set and enforce minimum qualification and practice standards.

The limitations of negative licensing (the code of conduct and prohibition order powers)

There is evidence that increasing numbers of consumers are lodging complaints with state and territory health complaints commissioners and in some instances, Commissioners have taken action against so-called 'naturopaths', including by issuing prohibition orders (Doolan 2024).

A negative licensing or 'code regulation' scheme is now in operation in six Australian states (Australian Capital Territory, New South Wales, Queensland, South Australia, Victoria and Western Australia), but at the time of writing it is yet to be implemented in Tasmania or the Northern Territory.

The six schemes operate in broadly the same way.

There are some deficiencies in these arrangements which, when considered in light of the risk profiles of the naturopathy and WHM professions, raise concerns about the adequacy of the protections afforded consumers and the effectiveness of this mechanism in the absence of other controls over professional practice.

First, the threshold for regulatory action by a complaints commissioner is generally 'serious risk to public health or safety' or commission of a serious criminal offence, that is, an offence punishable by imprisonment. This is a very high threshold for regulatory action. As a consequence, only the most egregious cases result in regulatory action and a prohibition order (Lloyd et al., 2021: 51). Presumably if a complaint is not suitable for conciliation, it is closed without further action.

Second, these code of conduct and prohibition order powers have been implemented in only six out of eight states and territories. In the remaining jurisdictions, there is no statutory code and no powers to issue prohibition orders even in the most egregious cases – see **Table 3.5**.

Third, given the harms that have been reported, complaints mechanisms appear to be underutilised, in some cases lacking in transparency and are not standardised across jurisdictions. The level of information available to the public concerning prohibition orders issued under the six schemes is highly variable. For example, in Victoria, virtually no information is published on the website of the Health Complaints Commissioner when a prohibition order or interim prohibition order is published. It is questionable how members of the public are protected from practitioners who are unfit to practise if the most basic information about the nature of the misconduct that led to the prohibition order remains confidential.

A recent study of the operation of these negative licensing schemes (Doolan, 2024) has found inconsistencies and gaps in the way the state and territory HCE schemes operate:

- There is no standardisation in the reporting of complaints data across the jurisdictions, so it is difficult to compare the schemes against the most basic of performance indicators such as number of complaints received per year by occupational group, nature of complaints, outcomes, number of prohibition orders issued etc. For example, while NSW provides an annual breakdown of complaints against types of unregistered health practitioners, Queensland and Victoria do not.
- In NSW, prohibition orders may be removed once they have expired, whereas in Queensland ('Qld') prohibition orders may be removed if the Health

5 See Australian Government Private Health Insurance Rules.
6 The Dept of Home Affairs website indicates that the Australian Association of Social Workers, Dietitians Australia and Speech Pathology Australia are the professional associations authorised to assess overseas practitioners for skilled migration purposes. See www.immi.homeaffairs.gov.au/visas/working-in-australia/skills-assessment/assessing-authorities
7 The United Kingdom Government operates a co-regulatory scheme in the form of its Voluntary Registers Program.

Ombudsman ('HO') or the Queensland Civil and Administrative Tribunal ('QCAT') revokes the prohibition order. This means the numbers of prohibition orders reported in the NSW Health Care Complaints Commission ('HCCC') and Qld Office of the HO (OHO) Annual Reports do not accord with those available on their websites.

- Unlike the NRAS:
  - there is no link or permanent record of disciplinary decisions provided to the public for unregistered health practitioners, and
  - there is no national register of prohibition orders available for the public to easily search to check unregistered practitioner qualifications or details.
- Information available on the type of practitioner issued with prohibition orders is variable, with a lack of adequate description on the Queensland and Victorian websites.
- Many of the prohibition orders provide no detail or reasons why a prohibition order was made.

Fourth, the use of the prohibition order powers is largely reactive, with regulatory action triggered usually once harm has already occurred (Lloyd et al., 2021: 51). Such schemes do not provide the infrastructure to enable proactive and non-punitive quality assurance measures to be applied. Minimum levels of practitioner training and probity checks are not enforceable, nor are education programs to assist practitioners to identify and prevent inappropriate practice behaviours – measures that would be expected to prevent recidivism and reduce the risk of breaches by other practitioners (Lloyd et al., 2021: 51).

Also, a recent study found the proportion of complaints that result in a prohibition order removing the practitioner from practice appears to be higher for unregistered practitioners under code regulation in NSW compared with removals (cancellation or suspension of registration) for practitioners under the NRAS (Doolan 2024). The NSW HCCC has stated that investigations of unregistered practitioners *'tend to raise serious concerns of public health and safety and generate intensive and complex investigations'* (NSW HCCC 2020: 55). These findings suggests that while the prohibition order powers may be serving an important public protection function, stronger regulation with a preventive focus may be warranted.

Lack of access for naturopaths to their tools of the trade

The current system of restricting access to toxic herbs via the Standard for Uniform Scheduling of Medicines and Poisons (SUSMP) means competent naturopaths are denied access to some important herbs used in naturopathic treatment. The effect of these scheduling arrangements places a range of herbal medicine products out of reach of those practitioners who are trained to use them.

It is a perverse outcome of the scheduling arrangements that only registered medical practitioners (for schedule 4 medicines) and pharmacists (for schedule 2 and 3 medicines) are authorised to prescribe these herbal medicines, but without the necessary training to do so safely and competently.

Conclusion regarding Criterion 3:

The **risk profiles of the naturopathy and WHM professions are substantial**, compared with those professions already regulated under the NRAS and there is a pattern of harm to consumers that is not being adequately addressed under current regulatory arrangements.

The existing mix of self-regulatory, co-regulatory, negative licensing, and other mechanisms are failing to adequately address the risks of harm associated with unregulated naturopathic and WHM practice.

Without enforceable controls over entry to practice in the profession, there are no effective mechanisms to enforce minimum practice standards and no effective methods of preventing unqualified individuals from continuing to practice. People who have no qualifications whatsoever, those who been expelled from a professional association for misconduct, and those deregistered from other regulated professions, cannot be prevented from entering practise as a naturopath or herbalist.

The institutional failures outlined here reflect the broader power relations embedded within the Australian healthcare system that maintain the marginalised position of the naturopathy and WHM professions. Attitudinal barriers mean that naturopaths and herbalists are excluded from many mainstream healthcare settings and benefits, making it difficult to influence government policy decisions that affect their interests.

The end result is that patients are more exposed and vulnerable to fly-by-night opportunists who lack proper naturopathic or WHM qualifications and are disposed to flout professional norms and exploit the trust and vulnerabilities of their patients for personal gain.

Existing regulatory mechanisms are failing to deal with this fundamental problem.

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

Naturopathy and WHM are well-defined and widely practised health professions in Australia. This is evidenced by the following:

The Australian and New Zealand Classification of Occupations (ANZCO) designates naturopathy as occupational Skill level 1, bachelor's degree or higher.[8] This is equivalent to other health occupations such as dentists, general practitioners, nurses, optometrists, and pharmacists.

The naturopathy and WHM professions have a well-established body of knowledge:

- The World Health Organization (WHO) has issued benchmarks for training in naturopathy to ensure practice meets minimum levels of adequate knowledge, skills, and awareness of indications and contraindications (WHO, 2010: viii).
- The World Naturopathic Federation (WNF) has issued a *Naturopathic Educational Program Guide* to promote accreditation of naturopathic educational programs and the highest educational standards for the naturopathic profession globally (WNF, 2022).
- Education programs for naturopaths and herbalists for entry to practice have been offered at tertiary level in Australia for over five decades.
- Naturopathy/WHM curricula have been developed at bachelor's degree level and offered by several universities.
- Standards for accreditation of education programs in both naturopathy and WHM have been published by ARONAH[9] and in 2022, ARONAH issued updated *Competency Standards for Naturopathic Practitioners and Competency Standards for Western herbalists*, following an extended consultation with the profession and key stakeholders.[10]

It is, therefore, possible to define these professions and their respective bodies of knowledge sufficiently for the purposes of regulation.

Conclusion regarding Criterion 4:

Regulation is possible to implement for the naturopathy and WHM professions – they are well-defined and well-established health professions in Australia. They have an established body of knowledge, modalities, principles and philosophies, and established education and practice standards.

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

There are established precedents for statutory registration of naturopaths and herbalists – these professions are recognised and regulated by statute in many jurisdictions, including the USA and Canada (Lloyd et al., 2021). There are also precedents for registration of T&CM professions in Australia (osteopathy, chiropractic and Chinese medicine) including where the use of ingestive therapies (herbal medicines) is a component of the scope of practice.

Chinese medicine has been successfully regulated under a protection of title model, first in Victoria from 2000 and then nationally under the NRAS since 2012.

While similar practical issues would be expected to arise with registration of naturopaths and herbalists, these are not insurmountable, and the number of potential registrants would be expected to be considerably higher than for the Chinese medicine profession, providing the economies of scale necessary to keep registration fees relatively low.

Four out of five professional representative bodies support statutory registration for the naturopathy and WHM professions and surveys of practitioners have consistently shown that a majority are supportive of registration and are willing and able to finance and support a self-funded National Board.

Conclusion regarding Criterion 5:

Regulation is practical to implement for the naturopathy and WHM professions. Introduction of statutory registration is not without some practical challenges. However, experiences in other jurisdictions and with inclusion of the Chinese medicine profession within the NRAS show that these **challenges are solvable**. These precedents can be drawn upon in implementing appropriate arrangements for the naturopathy and WHM professions.

8 See ANZCO.
9 See ARONAH website https://www.aronah.org/course-accreditation/
10 See ARONAH.

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

A Regulation Impact Statement (RIS) would be expected to assess several options for occupational regulation of naturopaths and herbalists, including:

- professional association run registers with member certification – the status quo (no change)
- supporting self-regulation through co-regulatory partnerships with government – for example, via a quality assured voluntary registers scheme
- strengthening negative licensing – state and territory codes of conduct with powers to issue enforceable prohibition orders
- statutory registration – under the NRAS

Chapter 10 of this report compares key features of each type of occupational regulation.

The preferred option – statutory registration of naturopaths and herbalists under the NRAS.

Some naturopathy practices pose a significant risk of harm, and these risks are compounded by the primary healthcare context, the broad scope of practice of naturopaths and the lack of institutional supports for assuring and monitoring the quality and safety of services.

Existing regulatory mechanisms are inadequate for safeguarding and protecting consumers. There are definable modalities, an established scope of practice, and body of knowledge for which it is possible to implement regulation. There are some practical challenges, but implementation lessons can be drawn from the experience of introducing national registration for the Chinese medicine profession in 2012 and more recently the paramedicine profession in 2018. The benefits of protecting public health and safety through statutory registration are considered to outweigh the potential adverse effects.

Statutory registration is warranted given the scopes of practice of naturopaths and herbalists, the risks associated with their practice, and the range of harms to the public that arise from uncontrolled entry to these professions. There are risks associated with the use of ingestive medicines which are exacerbated if practitioners are not properly trained about indications, contraindications, and the interactions between naturopathic/herbal medicines and pharmaceutical drugs.

Existing regulatory arrangements are insufficient to protect the public from unqualified or under-qualified practitioners. A pattern of harm has been established over at least three decades, harm that has proven unresponsive to existing regulatory mechanisms and efforts by some professional bodies to raise standards.

The code of conduct and prohibition order powers of health complaints commissioners in six states (negative licensing) provide insufficient public protection because commissioners are generally alerted only after a patient has suffered harm. These powers do not prevent unethical persons from setting up practice where they see an opportunity to benefit financially by exploiting vulnerable patients. The cases presented in this study show a pattern of harm that is likely to continue without stronger controls over entry to the profession.

Statutory registration would provide more robust and effective complaints and disciplinary processes. Under statutory registration, the regulation and representative functions of professional associations would be separated, thereby reducing the possibility of conflicts of interest. Professional associations would be able to focus their resources on support of their members and professional development. Members of the public would be able to readily identify a qualified practitioner and would have greater trust and confidence that these professions are properly regulated and accountable.

Conclusion regarding Criterion 6:

This report provides prima facie evidence of the need for statutory registration for the naturopathy and WHM professions and that the substantial benefits of regulation are expected to outweigh the costs. This assessment demonstrates that existing mechanisms for protecting the public are inadequate and that statutory registration is the only option that will provide sufficient protection from harm for patients, given the risk profile of these professions.

1
INTRODUCTION TO THE NATUROPATHS' REGULATION RESEARCH STUDY

1.1 BACKGROUND

Introduction

Demand for the health care services provided by naturopaths and Western herbal medicine practitioners (herbalists) has been a consistent feature of the Australian healthcare landscape for generations. Each year, a sizeable proportion of Australian consumers choose to see a naturopath or herbalist, to help maintain their health, prevent illness, and treat acute and chronic health conditions.

Naturopaths and herbalists are a non-registered workforce and operate principally in private practice and outside the public health system.

In Australia, any person who provides a health service is subject to various laws that govern and shape their practice. This includes the civil law (the law of contracts and of negligence), the criminal law, laws that govern public health risks, the use of medicines and therapeutic goods, and laws on health complaints and workplace health and safety.

Members of some health professions are also subject to occupational licensing or 'statutory registration' under Australia's National Registration and Accreditation Scheme for the health professions (NRAS).[11] The main purpose of this scheme is to protect the public from harm by setting and enforcing educational standards for entry to these regulated professions, registering suitably qualified persons, regulating their practice and where necessary, removing unfit practitioners from the workforce.

The professions of naturopathy and Western herbal medicine (WHM) are not included under the NRAS and therefore are known as 'self-regulating' professions.

Some professional associations that represent naturopaths and WHM practitioners (herbalists) have long sought occupational regulation (statutory registration) (see Appendix 1.1 for a list of key events and decisions). The last formal submissions to government seeking statutory registration for these professions were made in 2005 (Lin et al.) and 2016 (Weir).

In 2020, the Australian Naturopathic Council (ANC) decided to try again. Prior to preparation of a further submission, the ANC decided to commission Dr Anne-Louise Carlton from RMIT University, an internationally recognised expert in health practitioner regulation policy and practice, to put together a team of researchers to undertake a study of the regulatory requirements for the professions of naturopathy and Western herbal medicine.

Purpose of this study

The purpose of the study was to investigate and understand the practice of naturopathy and WHM in Australia and to make recommendations on the need, if any, for measures to strengthen regulation to better protect the public. The findings of the study were expected to build on an earlier government-commissioned study from 2003-05 (Lin et al., 2005) and inform the preparation of a submission from ANC member organisations to state, territory, and federal governments, seeking the inclusion of naturopaths and herbalists in the NRAS.

The Australian Register of Naturopaths and Herbalists (ARONAH) agreed to act as the commissioning body for the study on behalf of ANC member organisations. The study was financed by members of the naturopathy and WHM professions following a successful crowdfunding campaign. A matched grant of $20,000 was provided by Dr Marcus Blackmore AM. Substantial volunteer resources were provided by ANC member organisations and naturopathy academics.

11 There are 16 professions regulated under NRAS including the professions of Chinese medicine practitioners (including Chinese herbal medicine practitioners, acupuncturists and Chinese herbal dispensers), chiropractors and osteopaths.

Textbox 1.1: The Australian Naturopathic Council

The Australian Naturopathic Council (ANC) is a group comprising professional associations that are full members of the World Naturopathic Federation, education providers, and a voluntary registering body – all working together towards common objectives (see www.naturopathiccouncil.org.au/). These objectives include government statutory registration for the naturopathy and Western herbal medicine (WHM) professions.

Current membership of the ANC consists of:

- Australian Register of Naturopaths and Herbalists (ARONAH)
- Complementary Medicine Association (CMA)
- Endeavour College of Natural Health
- Naturopaths and Herbalists Association of Australia (NHAA)
- Torrens University Australia (incorporating Southern School of Natural Therapies (SSNT) and Australasian College of Natural Therapies (ACNT))
- Southern Cross University

The Lin Report of 2005

The methodology for this study was drawn from an earlier report published in 2005 titled ***The Practice and Regulatory Requirements of Naturopathy and Western Herbal Medicine***.

Known as the Lin Report, this study was commissioned by the Victorian Government Department of Human Services (DHS) in June 2003, following completion of a regulatory assessment process for the profession of Chinese Medicine. DHS contracted a team of researchers led by Professor Vivian Lin from the School of Public Health at La Trobe University, to undertake research on the benefits, risks, and regulatory requirements for the profession of naturopathy including WHM. The aim of that study was to investigate and understand the practice of naturopathy and WHM in Australia and to make recommendations on the need, if any, for measures to protect the public.

The Lin Report documented substantial risks associated with the practice of naturopathy and assessed the need for statutory registration for naturopaths and WHM practitioners. It recommended to governments that statutory registration be introduced in Australia for the naturopathy and WHM professions.

The Lin Report is available at the Victorian Department of Health website.

The establishment of the National Registration and Accreditation Scheme

Since the Lin Report was published, the way the health professions are regulated in Australia has been overhauled – the previous state and territory-based registration schemes have been abolished and a single national multi-profession registration scheme established.

In 2010, the NRAS commenced operation with 10 nationally regulated health professions. In 2012, following a long campaign that started in earnest in Victoria in the mid-1990s, the Chinese medicine profession was successful in securing national registration under the NRAS.

There are now 16 health professions regulated nationally under the NRAS, including chiropractic, osteopathy and most recently, paramedicine entered the scheme on 1 December 2018.[12] Each profession is regulated by its own National Board, with administrative support provided by the Australian Health Practitioner Regulation Agency (Ahpra). For more information on the NRAS and Ahpra, go to the Ahpra website.

National registration brings a new process for regulatory assessment

Under the legislation that established the NRAS, the Health Ministers Council (HMC)[13] is the inter-government decision-making body that approves legislative changes to expand the scope of the NRAS to include additional health professions. Although the NRAS commenced operation in 2010, it was not until the end of 2018 that governments published long-awaited guidance for professional associations about how to apply for inclusion of a profession in the NRAS.

The criteria and process for regulatory assessment of extra professions for inclusion in NRAS are set out in the document titled *AHMAC Information on regulatory assessment and process for adding new professions to the National Registration and Accreditation Scheme for the health professions* (AHMAC, 2018). This national process provides for a professional association that represents members of an 'unregistered' health profession to make a submission to any participating jurisdiction (a state, territory, or federal government) to request a regulatory impact assessment in accordance with the AHMAC process. The criteria to be addressed in a submission are set out in **Attachment 1.2**. To read more about these **AHMAC regulatory assessment guidelines** go to the **Ahpra website**.

In light of publication of this intergovernmental regulatory assessment process, the ANC members considered it timely to revisit the work of the Lin Report and ask governments to reconsider the need for statutory registration for the naturopath and WHM professions.

12 See: https://www.paramedicineboard.gov.au/News/2018-11-30-Paramedics-Welcome-to-the-National-Scheme.aspx

13 The Health Ministers' Meeting and its advisory body, the Health Chief Executives Forum (HCEF) provide a mechanism for the Australian Government, the New Zealand Government, and state and territory governments to discuss matters of mutual interest concerning health policy, services and programs. See https://www.health.gov.au/committees-and-groups/health-ministers-meeting-hmm

1.2 OBJECTIVES AND SCOPE OF THIS STUDY

The scope of this study encompasses both naturopathic and WHM practice and practitioners. The objectives are set out in Textbox 1.2.

Textbox 1.2: Objectives of the Naturopathy Regulation Research Project

1. To conduct research to provide an up-to-date profile of how naturopathy and Western herbal medicine are practised and organised in Australia, including:

   Consumers – the consumers who use the services of naturopaths and/or WHM practitioners

   Risks and benefits – the evidence concerning the risks and benefits associated with the practice of naturopathy and WHM

   Workforce – the size, composition, and distribution of the Australian naturopathy and WHM workforce

   Education – the programs and educational institutions that train naturopaths and herbalists for entry to practice in the profession and provide continuing professional development

   Professional representation – the arrangements through which the professions of naturopathy and WHM are represented

   Institutional recognition – the extent of recognition of the naturopathy and WHM professions by institutions such as public and private health insurers, governments, and regulators

   Regulation – the regulatory arrangements that govern the practice of naturopaths and WHM practitioners.

2. To provide an evidence-informed research report to inform deliberations by governments and stakeholders about the need to strengthen occupational regulation of the naturopathy and WHM professions.

This study builds upon, and updates evidence presented in the 2005 Lin Report. Amongst other things, this study includes a systematic examination of the literature published since 2005 on the Australian naturopathy and WHM workforce and the consumers who use the services of naturopaths and herbalists, as well as the results of surveys of the education arrangements for training of naturopaths and herbalists for entry to practice, and the professional representation arrangements (the associations and groups that represent naturopaths and herbalists); and an analysis of the risks associated with the practice of naturopathy and WHM.

1.3 GOVERNANCE OF THE PROJECT AND CONSULTATIONS

Governance

The members of the ANC established a Research Reference Group in September 2020 to oversee the study. The Reference Group comprised nominees of each of the members of the ANC and met monthly throughout 2020-24. A nominee of the National Centre for Naturopathic Medicine at Southern Cross University (SCU) was invited to join the group in May 2023.

The members of the research team responsible for the various components of the study are listed in the acknowledgements. Some of the researchers who contributed to the original Lin Report were also invited to assist with the study.

Public consultations

Information on the conduct of this study was published on the websites of the ANC and its member organisations. Three e-bulletins were published to provide progress reports on the project – see ANC website.

A virtual townhall was held on 14 June 2022 with a panel of experts discussing statutory registration for the naturopathy and WHM professions. Over 1240 participants registered to attend. A poll held following the event indicated that 54% of respondents supported statutory registration for the naturopathy profession and 90% wanted another townhall panel discussion, suggestive of the interest of practitioners in the issue of registration.

1.4 TERMINOLOGY AND DEFINITIONS

Naturopathy

Naturopathy, also called naturopathic medicine, is a medical system that has evolved from a combination of traditional practices and health care approaches popular in Europe during the 19th century.[14] It is defined by its core principles of holism and vitalism, and its practice is guided by distinct naturopathic theories.

A brief history of the evolution of naturopathy is found in the Lin Report (2005: 24-26).

14 See Lin & colleagues (2005: 24-26) for a summary of the evolution of the practice of naturopathy & WHM.

The WNF's Health Technology Assessment describes naturopaths and naturopathic practice as follows:

- Naturopaths are medically trained practitioners who use a breadth of natural treatment modalities and practices in the provision of person-centred healthcare (Lloyd et al., 2021: xxv).
- Naturopathic practice has always been therapeutically diverse in its approach to healing and incorporates various therapeutic modalities and practices that are applied based on the naturopathic philosophical and traditional framework. It is complex and multi-modal and incorporates core naturopathic therapies, modalities and practices including nutritional medicine, herbal medicine, lifestyle modification, mind-body medicine, and counselling (Lloyd et al., 2021: viii).
- A naturopath employs a range of assessment tools including a thorough case history, standard conventional physical examinations and laboratory testing, along with traditional naturopathic assessment techniques such as tongue and pulse diagnosis. The three main goals of a naturopathic assessment are to first determine the factors contributing to a patient's state of health, their symptoms and/or diseases; second, collect the proper information to inform a naturopathic diagnosis; and third, assess the patient's vitality and state of wellbeing (Lloyd et al., 2021: ix).

The *Australian and New Zealand Standard Classification of Occupations* (ANZSCO) describes naturopathy as a practice that treats internal health problems, metabolic disorders and imbalances through the treatment of the whole person using natural therapies. The practices of complementary health therapists, such as naturopaths, include assessing patients to determine the nature of the disorder, illness, problem or need by questioning, examining and observing, and includes the use of herbal medicine prescriptions, and dietary and lifestyle advice and guidelines as treatments (ANZSCO 2014).[15]

The Australian Government-authorised professional qualifications assessment authority, VETASSESS, has assessed naturopathy as a Group A occupation which requires qualifications comparable to the educational level of an Australian Qualifications Framework (AQF) bachelor's degree or higher, in a field highly relevant to the nominated occupation[16] (VETASSESS 2024).

For the purposes of this study, a naturopath is a health practitioner who has core training in naturopathic principles and philosophy, and in at least three of four practice modalities: (i) herbal medicine; (ii) nutritional medicine; and either (iii) massage or (iv) homeopathy. The modalities encompassed by naturopathy may be practised as single modalities, that is, either naturopaths or other practitioners may have a practice consisting of only one modality. However, this report does not encompass those practitioners whose training and practice are in the single modalities of massage, nutritional medicine (sometimes called 'clinical nutrition'), homeopathy or counselling.

People visit a naturopath or herbalist for various health-related purposes, including primary care, overall wellbeing, and treatment of illnesses, both acute and chronic.

Western herbal medicine

Western Herbal Medicine (WHM) is a clinical practice of healing using naturally occurring plant material or plants with little or no industrial processing. Medicines or extracts from crude plant material, such as root, bark, and flower, are used in multiple plant formulations to treat persons with disease and dysfunction and to promote health and well-being. WHM is a title recently used to differentiate herbalism based on Anglo-American traditional herbal medicine from other systems of herbal medicine such as Ayurveda or Traditional Chinese Medicine (Niemeyer 2013: 1-2).

WHM is practised principally by two professional groups, herbalists and naturopaths. Both will usually combine herbal treatment with diet and lifestyle advice (Wohlmuth, Oliver & Nathan, 2002: 37).

Western herbal medicine practitioner (herbalist)

For the purposes of this study, a 'Western herbal medicine practitioner' is a person who provides health services that involve the extemporaneous compounding of herbal medicines for therapeutic purposes, for individuals under their care and has:

- satisfactorily completed core training in the principles, philosophy and practice of herbal medicine
- achieved the competencies set out in ARONAH's *Competency Standards for Western Herbalists*.

The term 'herbalist' is used interchangeably with WHM practitioner throughout this report.

This report is concerned only with naturopathy and WHM, and it therefore does not consider a range of other traditional and complementary therapies or practices (such as kinesiology, reflexology, iridology, Reiki, Bach flower therapy, aromatherapy, Ayurvedic medicine, and so on).

Traditional and complementary medicine

Naturopathy and WHM are typically included under the umbrella term 'traditional and complementary medicine' (T&CM). In its Traditional Medicine Strategy (2014 – 2023), the World Health Organization (WHO) provides the following definition of T&CM:

> *Traditional medicine has a long history. It is the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not,*

15 See ANZSCO Classification structure at https://www.abs.gov.au/statistics/classifications/anzsco-australian-and-new-zealand-standard-classification-occupations/2022/browse-classification/2/25/252/2522

16 See VETASSESS website at https://www.vetassess.com.au/check-my-occupation/professional-occupations/naturopath

used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.

The terms 'complementary medicine' or 'alternative medicine' refer to a broad set of health care practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant health-care system. They are used interchangeably with traditional medicine in some countries (WHO 2013: 15).

1.5 ORGANISATION OF THIS REPORT

The findings of this study are presented as follows:

Chapter 1: Introduction (this chapter)

This introductory chapter presents an overview of the scope and governance of the study, its objectives, and the policy context within which the study was undertaken. The chapter concludes with this overview of how the report is organised.

Chapter 2: Consumer expectations and use of naturopathy and WHM

This chapter presents the results of a systematic review of research literature on the characteristics of consumers who use the services of naturopaths and herbalists. It synthesizes available research literature published since 2005, to understand the consumer demographics, motivations and reasons for use, the consumer experience of naturopathic and herbalist care, and prevalence, that is, the proportion of the population who use services of naturopaths and herbalists in Australia.

Chapter 3: Risks associated with the practice of naturopathy and WHM

This chapter presents an analysis of data on the risks associated with the practice of naturopathy and WHM. It includes a risk profile for naturopathy and compares this with the 16 professions registered and regulated under the NRAS. It draws on data gathered from health complaints bodies and professional associations, documenting cases from the media, court and tribunal reports on complaints about naturopaths and herbalists, or those purporting to be naturopaths or herbalists, and how these have been dealt with.

Chapter 4: Benefits associated with use of naturopathy and WHM

This chapter presents an overview of the scientific literature on the benefits of naturopathy and WHM practice. To illustrate the scale and scope of the scientific literature, this chapter includes a bibliometric analysis of citations in the published literature concerning the 'tools of trade' of naturopaths and herbalists and key modalities employed in naturopathic and WHM practice, that is, herbal medicine and nutritional supplements. It also presents a critical review of five key studies that have assessed the benefits of naturopathy and WHM.

Chapter 5: The Australian naturopathic and WHM workforce

This chapter presents the results of a systematic review of the empirical evidence published since 2005 concerning the characteristics of the naturopathic workforce in Australia, including the demographic features of the workforce, the nature of naturopathic and WHM practice, the profile of patients who use naturopathy and WHM services, and the professional and interprofessional issues reported by naturopaths and herbalists.

Chapter 6: Australian naturopathic and WHM education

This chapter presents the results of a survey of Australian naturopathy and WHM education providers, undertaken in June-July 2021. The chapter presents a profile of education providers and the programs of study available for entry to practice and postgraduate education for naturopaths and herbalists. Key changes in the sector since 2005 and issues confronting the profession with respect to education are discussed.

Chapter 7: Professional representation of naturopaths and WHM practitioners

This chapter presents the results of a survey of the professional associations that represent naturopaths and herbalists, including their membership profiles, codes and guidelines issued, standards, policies, and procedures, and views about regulation and other issues of importance to the professions. The chapter draws on data from two main sources: the findings of a survey of professional associations undertaken in June-July 2021, supplemented by searches of publicly available information posted on the websites of professional associations, including for those associations that did not respond to the invitation to participate in the survey.

Chapter 8: Institutional recognition of and support for naturopathic and WHM practice in Australia

This chapter documents and analyses the broader institutional arrangements that intersect with and shape the practice of naturopathy and WHM in Australia, in particular, the extent to which the institutions of government and civil society recognise and engage with naturopaths and herbalists and their practice. The purpose is to better understand where the naturopathy and WHM professions sit within the health care system and the institutional linkages and relationships that operate to integrate or segregate their practice. This analysis supplements and extends the findings from Chapter 7 on naturopathic and WHM professional associations and certification bodies.

Presented are the findings of enquiries made of a variety of institutions both government and non-government, including health insurers (public and private), professional indemnity insurers, statutory regulators, higher education regulators, research institutions, hospitals, professional associations, and other interest groups that represent the health professions generally.

Chapter 9: Regulation of naturopaths and WHM practitioners

This chapter documents and analyses the current regulatory arrangements that apply to naturopaths and herbalists in Australia and describes developments in occupational regulation of the naturopathy and WHM professions internationally.

Chapter 10: Assessing the need for statutory registration of naturopaths and WHM practitioners

This final chapter brings together the evidence from previous chapters and considers this evidence against the IGA criteria for assessing the case for statutory registration of a profession under the NRAS.

The chapter provides an overview of various models for occupational regulation of the health professions, including voluntary certification, co-regulation, negative licensing, and statutory registration, and the applicability of these to the professions of naturopathy and WHM.

The chapter concludes with the research team's recommendations for strengthening occupational regulation of naturopaths and herbalists.

2
CONSUMER EXPECTATIONS AND USE OF NATUROPATHY AND WESTERN HERBAL MEDICINE

Amie Steel & Sophia Gerontakos

2.1 INTRODUCTION

The health care choices that consumers make determine the extent of demand for naturopathic and herbal medicine services. Successive studies since the late 20th century, both in Australia and internationally, have found that consumer demand has seen considerable growth in the demand for and use of T&CM services, and their use alongside mainstream health care (Clarke et al., 2015; Leach, 2013; Lee et al., 2022; MacLennan, Wilson & Taylor, 2002; 2005).

A study by the WNF (Lloyd et al., 2021) found that in the last 40 years there has been substantial growth and expansion internationally in the number of naturopathic educational programs, attributed in part to increasing consumer demand for healthcare that focuses on prevention and offers a broader range of natural treatment options (Lloyd et al., 2021: 21).

The WHO has estimated that the naturopathic workforce includes more than 110,000 naturopaths/naturopathic doctors practising in over 108 countries spanning all WHO Regions, with approximately 10,000 in the Western Pacific Region, mostly in Australia and New Zealand (WNF, 2019).

In 2003-04, Lin & colleagues conducted a study of consumers of naturopathy and WHM in Australia. The aim was to understand why people use natural therapies, what they use, and their attitudes and experiences. The study included a literature review, the results of a survey that established a profile of patients attending naturopaths and herbalists in Australia, and the results of focus group research carried out with Victorian consumers (Lin et al., 2005: 233-53). Key findings from this study are set out in Textbox 2.1.

In the 20 years since, further studies have examined the characteristics and experiences of consumers who use the services of naturopaths and herbalists.

The purpose of this chapter is to present the results of a systematic review of this published empirical research. The aim is to synthesise the available research literature published since 2005 to better understand the prevalence of use, that is, the proportion of the population who use naturopathy/WHM services, the characteristics of consumers who use the services of naturopaths and herbalists in Australia, including the demographics, motivations and reasons for use, and the consumer experience of naturopathic care.

Textbox 2.1: Findings of Lin Report (2005) concerning consumers of naturopathy and WHM

Choice of practitioner and care: The majority of patients were self-referred, following recommendation from another person. People believed that they had made rational and well-informed choices about using different health practitioners for various health considerations. The main reasons included: (i) wanting effective treatments for health problems; (ii) maintenance of health and wellness; (iii) being treated for a chronic illness or condition; and (iv) dealing with the effects of medical treatment for a serious health condition. Treatment was sought for a wide range of physical and psychological problems; the majority were suffering from chronic or recurrent conditions. Treatments were multifaceted, with dietary advice being the most common, WHM, lifestyle advice, nutritional supplements, and exercise advice were also widely used.

Communication: The literature on Australian use of naturopaths suggests that communication between medical and complementary and alternative medicine (CAM) practitioners can be poor – which could have adverse consequences in terms of interactions between drugs and complementary medicines. Approximately half of the profiled patients had consulted a medical practitioner (general or specialist) for their complaints before visiting a naturopath, but communication between practitioners occurred in only a minority of cases.

Concurrent use of conventional medicine and naturopathy or WHM: Concurrent use of conventional medicine and naturopathy is widespread and across all age ranges; employed women in higher-income brackets tend to be the largest single group of users. Among the profiled patients who received naturopathic treatment, 34% were also taking pharmaceutical drugs.

Quality issues: Research participants took an active interest in their health and wellbeing, and this was reflected in their assessments of the quality of their treatments and their practitioners (all types); this was also reflected in participants' information-seeking behaviour and self-prescribing.

Regulation of practitioners: Regulation of naturopaths was favoured by the majority of focus group participants. Supporters said that regulation was needed to: (i) raise the standard of practitioners; (ii) ensure consistency of care; and (iii) stop unethical practices. Comments made in the focus groups suggested that consumers were of the view that regulation of naturopaths would enable consumers to navigate the two systems more easily and would facilitate better communication between CAM and medical practitioners.

Source: Lin et al., 2005: 249-51

2.2 METHODOLOGY

Four electronic databases were searched: MEDLINE (via Ovid), AMED (via Ovid), CINAHL (via Ovid) and Embase (via Ovid). All fields for each database were searched using a combination of "naturopath$" and "Australia". Search results were downloaded and saved as .RIS files on 23rd October 2020. Search files were imported to the web-based software package Covidence (Covidence 2023) for filtering and data extraction. Duplicates were identified and removed using the Covidence duplicate filter feature. Two researchers independently filtered the citations via title and abstract in accordance with the eligibility criteria. Any differences in classification were discussed between the researchers until consensus was reached. The full texts of the retained citations were sourced and checked for eligibility. Reference lists and citation trails of articles retained after checking the full texts were also checked to identify other relevant articles.

Articles were included if they presented original research published in a peer-reviewed journal between 2010 and 2020, specifically original research from observational studies including quantitative (e.g. survey) or qualitative (e.g. focus groups, interviews) methods that reported on the characteristics of Australian naturopathy consumers and their approach and experience of practice.

Articles were excluded if the Australian data were aggregated with data from other countries, or naturopathy/WHM workforce data were aggregated with data from other health professions.

Data were extracted through Covidence Extraction 2.0 using a template developed based upon similar previous systematic reviews. Extracted data were exported to a Microsoft Excel spreadsheet and then thematically categorised in separate tables in a Microsoft Word document. Data from the included articles were categorised into themes and, where appropriate, compared with the results of the earlier naturopathy consumers study published in the Lin Report (2005).

2.3 RESULTS

Figure 2.1 sets out the article selection process. The database search identified 756 articles. After the removal of 289 duplicates, 467 articles remained for screening. After examining articles against eligibility criteria and checking reference lists and citation trails, 376 articles were excluded, a further 60 articles were excluded following full-text screening and 31 articles were identified for inclusion in the review.

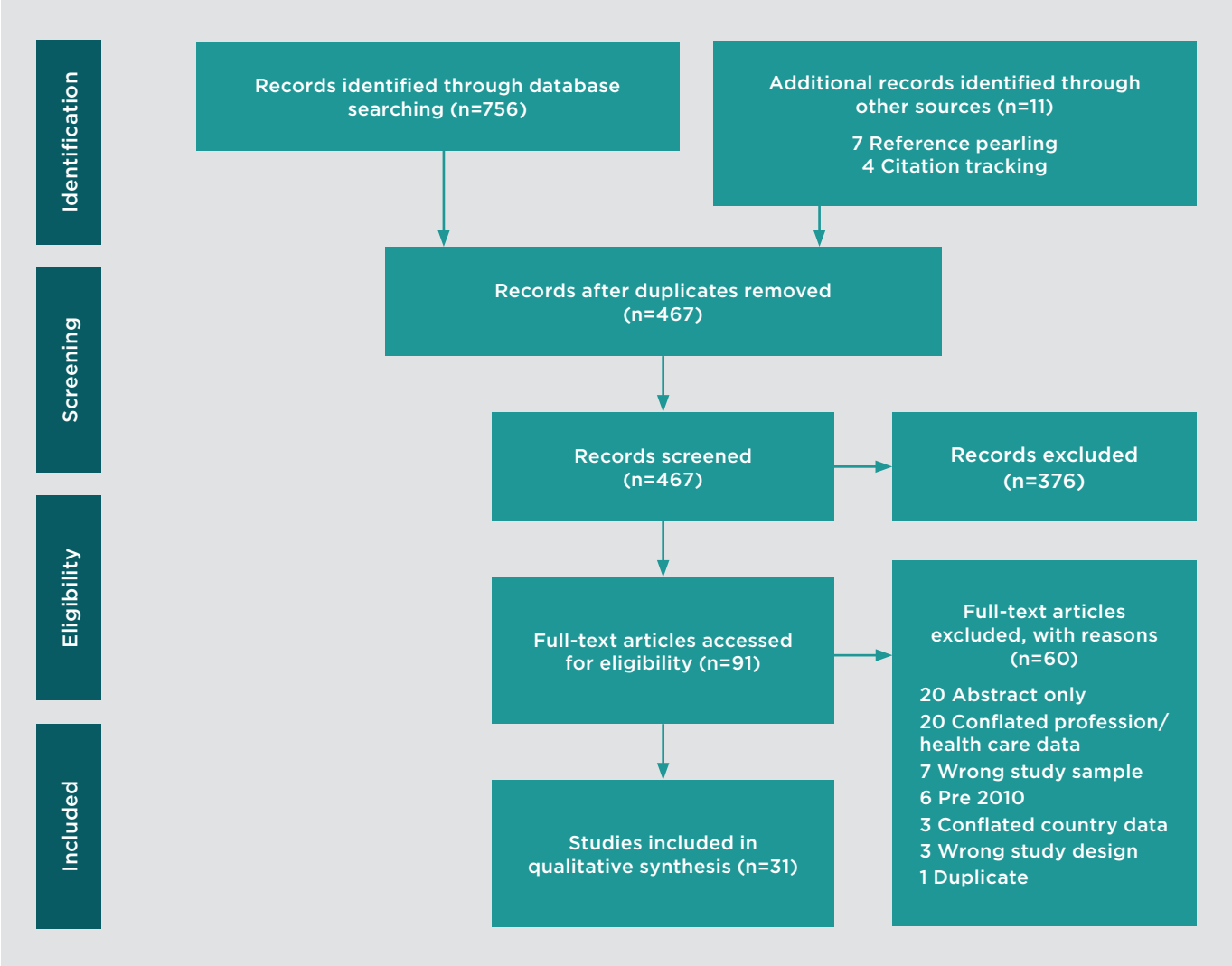

Figure 2.1: Article selection process and outcome

The included articles reported results from studies conducted using national (n=25) and regional (n=6) sample populations. All but one of the included articles employed survey research – from existing national samples (n=18), online surveys (n=6), health service/clinical settings (n=5) and pharmacy customers (n=1); with the remaining study employing qualitative interviews. Thirteen of the included articles presented data specifically on the naturopathic profession, 15 articles combined data from naturopathy and WHM practitioners and the remaining three articles did not differentiate between naturopathy and WHM practitioners. The 31 studies are detailed in Appendix 2.1.

Results of the analysis of included articles were categorised according to four main themes:

- Prevalence of use
- Consumer characteristics
- Consumer motivations and reasons for use, and
- Consumer experience of care

Prevalence of use of naturopathy services

Sixteen of the included articles presented data relating to prevalence of naturopathy and/or WHM consultations (Adams et al., 2013; Broom et al., 2012; Fisher et al., 2018; Foley et al., 2020a; Frawley et al., 2017a; Frawley et al., 2017b; Leach et al., 2020; Lucas et al., 2020; Malhotra et al., 2020a; McIntyre et al., 2019; Ng et al., 2020; Steel et al., 2012; Steel et al., 2017; Steel et al., 2018a; Steel et al., 2018b). Nine of those studies combined data from the naturopathy and WHM practitioners, five studies focused specifically on naturopathy practitioners and two studies did not differentiate between the two.

Appendix 2.2 (Table 2.1) presents a summary of the findings from these studies related to prevalence of use of naturopathy/WHM services. Key points:

- Two studies (McIntyre et al., 2019; Leach et al., 2020) reported on the prevalence of use of naturopathy services in the general population. Analyses conducted by McIntyre & colleagues and by Steel & colleagues from the same study found approximately 7.6% of people had consulted with a naturopath or WHM practitioner in 2018 (McIntyre et al., 2019; Steel et al., 2018a). In a separate study, Leach & colleagues (2020) found 9.2% of regional South Australian adults had consulted with a naturopath or herbalist in the previous 12 months.
- In a study of the patterns of usage of health services by Australian cancer patients, compared with the general population, Ng & colleagues (2020) found between 2.5% and 3% of people with cancer or cancer survivors had consulted with a naturopath in 2011-12 and in 2014-15 (13).
- In two separate surveys of women, Adams & colleagues (2013) found approximately 23% of middle-aged women had consulted with a naturopath (1) and Steel & colleagues (2012) found 7.2% of women who reported being pregnant or recently giving birth had consulted with a naturopath for pregnancy-related reasons (7).
- Fisher & colleagues (2018) found that women with endometriosis or who sometimes or often experience pre-menstrual stress (PMS) were 1.5 times more likely to consult with a naturopath than women without endometriosis or PMS (3). Steel & colleagues (2017) found that women who are attempting to conceive are more likely to consult a naturopath than those who are not ($p<0.001$) (3).
- Wardle & colleagues (2017) found that women who have not received a vaccination are more likely to consult with a naturopath than those who have received a vaccination ($p<0.001$) (9).
- In a national survey, Frawley & colleagues (2017a) found that 30% of parents who use complementary and alternative medicine (CAM) consult with a naturopath with their children (4) and Lucas & colleagues (2020) found that parents of children up to 12 years old who use CAM more commonly consult with a naturopath (50.4%) than a GP (25.6%) for acute respiratory tract infections.

Consumer characteristics

Seventeen of the included articles presented results that described the characteristics of consumers. Seven studies focusing specifically on naturopaths (Braun et al., 2010; Foley & Steel 2017; Foley et al., 2020a; Mak & Faux 2010; McIntyre et al., 2019; Murthy et al., 2014; Ng et al., 2020), eight studies combined data on consumer characteristics from those consulting naturopaths and WHM practitioners (Bowman et al., 2014; Fisher et al., 2016; Frawley et al., 2016; Peng et al., 2015; Sibbritt et al., 2010; Steel et al., 2012; Steel et al., 2016; Steel et al., 2017) and two studies did not differentiate between the two (Steel et al., 2014a; Steel et al., 2014b).

Appendix 2.2 (Table 2.2) presents a summary of the findings from these studies that document the characteristics of consumers who use the services of naturopaths or herbalists. Key points:

- Foley & Steel (2017) found that consumers of naturopathy are commonly female (87.3%) and 43% have a university or higher university degree. Similarly, McIntyre & colleagues (2019) found naturopathy and WHM users more commonly had a university degree (40.5%) compared to non-users, however unlike the previous study, the authors found no significant gender difference for naturopathy use.
- McIntyre & colleagues (2019) found that consumers of naturopathy services have one or more chronic diseases (74%). A total of ten studies reported on a variety of conditions that consumers consulted naturopaths for. These included chronic conditions such as diabetes, cancer, cardiovascular disease, respiratory illness, female reproductive conditions and mental illness (McIntyre et al., 2017); musculoskeletal conditions, gastrointestinal issues (McIntyre et al., 2017), back pain (Murthy et al., 2014; Peng et al., 2015; Sibbritt et al., 2010) menstrual or menopause symptoms (Peng et al. 2015; Sibbritt et al. 2010) and for pregnancy-related care (Bowman et al., 2014; Frawley et al., 2016; Steel et al., 2012; Steel et al., 2014b; Steel et al,. 2016).
- Several studies reported findings with respect to pregnancy. Naturopathy consumers who reported being pregnant or recently giving birth commonly consulted with a naturopath for back pain, nausea, tiredness, indigestion (Steel et al., 2012) and preparation for labour (Steel et al., 2012; Steel et al., 2014a); they were more likely to have consulted with a naturopath before pregnancy (Frawley et al., 2016) and were 2.5 times more likely to have private health insurance at the time of birth (Steel et al., 2014a).

- In relation to concurrent use of naturopathy and Western biomedicine, Murthy & colleagues (2014) found that nearly half (42%) of women who consulted with a naturopath for back pain reported having consulted with a GP more than three times.
- McIntyre & colleagues (2019) found that the majority (81.7%) of consumers of naturopathy report also using prescription pharmaceuticals or over-the-counter pharmaceuticals (75.9%). The authors also found that naturopathy consumers report financial difficulties some (43.8%) or all (21.6%) of the time with 35.3% holding a health care card, and 38.6% being covered by private health insurance.

Motivations and reasons for use

Four of the included articles presented data on consumer motivations and reasons for use of naturopathy (Caughey et al., 2020; Foley et al., 2020a; Malhotra et al., 2020a; McIntyre et al., 2019) with all four studies focusing specifically on naturopaths. The sample populations in these studies were: women who were long-term endometrial cancer survivors (Caughey et al., 2020); individuals with chronic illness (Foley et al., 2020a); individuals with self-reported sleep disorders (Malhotra et al., 2020a); and the general population (McIntyre et al., 2019).

Appendix 2.2 (Table 2.3) presents a summary of the findings from these studies. Key points:

- McIntyre & colleagues (2019) found that in the general population, of those consumers who consulted a naturopath, more than half (55.6%) did so to improve wellbeing.
- Several studies found that consumers are more likely to consult with naturopaths for long-term health conditions than acute conditions (Malhotra et al., 2020a; McIntyre et al., 2019) and to reduce their symptoms (Steel et al., 2016).
- Foley & colleagues (2020a) found that consumers reported consulting with a naturopath for long-term conditions (92.6%), as preventative health care (89.3%) and to enhance the effectiveness of medical treatments and medications (70.0%). The stated reasons for use of naturopathy were that consumers perceived their naturopathic health care professional as supportive and compassionate (100% strongly agree), the health care type as safe (93.3%), and the health care type giving a sense of control over their health (93.1%) (Foley et al., 2020a).

Consumer experience of care

Four of the included studies presented data on consumer reported experiences of care. Three of these studies focussed specifically on naturopathy practitioners (Foley & Steel, 2017; McIntyre et al., 2019; Foley et al., 2020) and one did not differentiate between naturopathy and WHM (Lucas et al., 2020). Sample populations were the general population (n=1) (McIntyre et al., 2019), parents of children (n=1) (Lucas et al., 2020) and patients with chronic illness (n=2) (Foley & Steel, 2017; Foley et al., 2020b).

Appendix 2.2 (Table 2.4) presents an overview of the findings from these studies related to the consumer experience of care. In summary:

- Foley & Steel (2017) found that patients with chronic illness rated naturopaths highly on a patient-centred care scale, with 100% of patients agreeing that they feel seen and heard as an individual by their practitioner and over 90% of patients agreeing that their practitioner was interested in them as an individual and was treating the root cause of their health problems (Foley & Steel, 2017). Patients agreed naturopaths are 'very good' or 'excellent' at listening (83.6%), showing care and compassion (94.5%) and 'helping you take control' (89.1%) and 100% of patients trusted their practitioner.
- In a second study, Foley & colleagues (2020b) found that patients were more likely to report feeling seen and heard, being listened to, having the root cause of their health issues addressed and trusting their naturopath compared to a GP and felt more empowered and in control of their health. They also found that patients were more likely to be satisfied their chronic illness care was well-organised with a naturopath (Mean: 4.71, standard deviation: 0.46) compared to a GP (Mean: 3.44, standard deviation: 1.19).
- Lucas & colleagues (2020) found that 42.6% of parents who use CAM for their young children use naturopaths as an information source.
- McIntyre & colleagues (2019) found that of those who consulted with a naturopath, half disclosed their use of all conventional medicines to the naturopath (50.4%) and 19.8% did not tell their naturopath about any of the conventional (pharmaceutical) medicines they use.

2.4 DISCUSSION

In 2005, Lin & colleagues found that use of T&CM was widespread, although at that time few reported studies provided a breakdown of usage by type of practitioner. There was limited population-wide data on the use of naturopathy and WHM services at that time.

Soon after, in 2007, a national survey by Xue & colleagues of the frequency of T&CM use in the Australian population found that 16% of the population had used WHM and 7.6% had used naturopathy in the previous 12 months, and of those, approximately 29% and 56% respectively had visited a practitioner.

Given the limited availability of comparative data, it is difficult to tell the extent to which use of naturopathy and WHM has either grown or contracted since 2007 when national population data was last reported. However, this study supports earlier findings, that naturopathy and WHM services continue to be used by a sizable segment (at least 7%) of the Australian population (McIntyre et al., 2019).

Consistent with earlier findings (Lin et al., 2005: 250), those who use naturopathy services are more likely to be female and on average are more highly educated than the general population. Studies show comparatively higher than average use by specific groups, such as middle-aged women, pregnant women, recent new mothers and women trying to conceive, women with various chronic conditions such as endometriosis and PMS, and cancer patients and survivors. The evidence also suggests that parents who use CAM are more likely to consult a naturopath than a GP for certain childhood conditions, such as respiratory infections.

The findings on the reasons for use of naturopathy and WHM are also consistent with earlier findings, that is, that people who consult naturopaths and herbalists do so for a range of reasons – a majority of consumers choose naturopathy for reasons of general health and wellbeing, to treat chronic health conditions, and for preventive health.

Satisfaction with naturopathic services is reportedly very high. Consumers report experiencing their practitioner as supportive and compassionate, the health care type as safe and giving them a sense of control over their health.

Like earlier findings (Lin et al., 2005: 249), concurrent use of Western biomedicine and naturopathy is well established, and many consumers continue to navigate two systems of healthcare. Concerns remain about the reported lack of communication between Western biomedicine practitioners (notably GPs) and naturopaths and herbalists. For instance, studies suggest that while over 80% of naturopathy consumers are using prescription or over-the-counter pharmaceuticals, only 50% are disclosing this use to their naturopath or herbalist. This is a concern given the evidence of interactions between herbal medicines and pharmaceutical drugs (see Chapter 3).

As noted previously (Lin et al., 2005: 250), consumers navigating between two systems of healthcare carries a heightened risk if they feel they cannot inform all practitioners about their use of particular services and medicines or if they choose not to.

The findings of this systematic review should be considered in light of some methodological limitations. While a systematic search protocol was employed, it is possible that some relevant manuscripts were missed if published in journals that were not indexed in the databases searched. Also, some studies were excluded as naturopathy user information was conflated with data about users of other health services. Despite these limitations, this review makes a substantial contribution to updating the findings from the Lin Report about the characteristics of users of naturopathy and WHM.

2.5 CONCLUSIONS

This chapter documents the characteristics of consumers who use the services of naturopaths and WHM practitioners.

The findings of this study, when combined with earlier studies, tell a story that has remained largely consistent over the last 30 years. A sizeable segment of the Australian population (at least 7%) chooses to use the services of naturopaths or herbalists to maintain health, prevent illness, and treat chronic health conditions.

Consistent with earlier studies, these consumers are more likely to be female and on average are more highly educated than the general population. There is comparatively higher use among certain groups, such as middle-aged women, pregnant women, those with chronic conditions and cancer patients and survivors.

These health consumers tend to be active in seeking health information and are using naturopathy and WHM to treat a wide range of chronic illnesses that involve every bodily system, as well as to maintain wellbeing, and for preventive health. The satisfaction of consumers with the services they receive from naturopaths and herbalists is very high. Consumers commonly use naturopathy and WHM concurrently with Western biomedicine and they often do not inform their GPs or their naturopaths or herbalists about this concurrent usage.

The need to navigate between two systems carries heightened risks, particularly if consumers feel they cannot inform key practitioners involved in their care about their use of particular services and medicines, or if they choose not to. Also, there are continuing concerns about the reported lack of communication between biomedicine practitioners (such as GPs and medical specialists) and naturopaths or herbalists, given the potential interactions between herbal medicines and pharmaceutical drugs.

Given that consumers are continuing to choose naturopathy and WHM, rather than ignoring this segment of the health workforce, it is incumbent on governments to develop specific policies that address issues concerning the quality and safety of these practitioners and the services they provide.

3

RISKS ASSOCIATED WITH THE PRACTICE OF NATUROPATHY AND WESTERN HERBAL MEDICINE

Anne-Louise Carlton, Jenny Carè & Angela Doolan

3.1 INTRODUCTION

Every health care practice carries risks. Assessing the need for occupational regulation of the naturopathy and WHM professions requires two steps: first, that the theoretical risks associated with practice be identified and documented; and second, that the available evidence be gathered and assessed about the extent to which these risks have been realised in practice and harms have occurred.

Many health service users believe complementary medicines and therapies are safe and do not interfere with Western biomedicine treatments (Foley et al., 2019). However, successive studies including of adverse events associated with the use of naturopathic medicines, both in Australia and internationally, present data that contradicts this view (Choudhury et al., 2023; Yan et al., 2022; Ali et al., 2021; Lin et al., 2005; Lloyd et al., 2021: 71-8; Myers & Cheras, 2004).

The purpose of this chapter is to document and analyse evidence of the risks and harms associated with naturopathy and WHM as it is practised in Australia.

This evidence is presented and analysed in four main parts.

First, an overview is presented of the main risks associated with the practice of naturopathy and WHM, supported by references from key sources, including a bibliometric analysis of the scientific literature on adverse events associated with the consumption of nutritional and herbal medicines, and case reports drawn from the searches of court and tribunal decisions and coronial inquiries.

Three categories of risk are identified: risks associated with the treatment modalities used by naturopaths and herbalists; risks associated with the scope of practice of naturopaths and herbalists; and risks associated with the practice context.

Second, a risk assessment tool is used to compare the risk profile of the naturopathy and WHM professions with the risk profiles of other health professions that are regulated under the NRAS. This risk assessment tool has been used in Australian government regulatory assessments to identify, classify, and compare the risks associated with the scopes of practice of health professions, when making decisions about whether to introduce new or strengthen existing occupational regulation.

Third, key findings are presented from two landmark studies that incorporated an assessment of the risks of naturopathic and WHM practice, that is, the Victorian State Government commissioned Lin Report (2005) and the World Naturopathic Federation's Health Technology Assessment (Lloyd et al., 2021).

Fourth, data is presented and analysed on complaints about naturopaths and herbalists reported by state and territory health complaints entities, and professional associations that represent these professions in Australia, comparing this data with earlier complaints data presented in the Lin Report.

Data from these various sources is synthesised to draw conclusions about the risks and harms associated with the practice of naturopathy and WHM.

3.2 METHODOLOGY

This chapter draws data from the following sources:

Database search of adverse effects

A citation search was carried out on 28 October 2022 in Ovid MEDLINE for the period 1950 to 2021, adopting the search terms used in the Lin Report (2005: 322). The search terms were modified to suit changes to database query options (see Appendix 3.1 for list of search terms). The search was rerun on 19 March 2023 to include citations for 2022.

Court judgments and tribunal and coroners' findings:

The following legal databases were searched for cases related to the practice of naturopathy/WHM – Austlii, Westlaw AU, NSW Caselaw and State Supreme Court. Tribunal websites searched included ACAT, VCAT, WACAT, SACAT, NTCAT, TASCAT, as well as publish decisions on the AustLII database. NCAT decisions were located on the NSW Caselaw website, and QCAT decisions on the SCLQ website. Findings of coroners' courts were located on state/territory coroner court websites.

State and territory health complaints entities (HCEs)

Websites of the following organisations were searched for statements of decision and details of prohibition orders, public statements or warnings

- the NSW Health Care Complaints Commission (NSW HCCC)
- Queensland Office of the Health Ombudsman (Qld OHO) and
- South Australian Health and Community Services Complaints Commissioner (SA HCSCC)
- Victorian Health Complaints Commission (VIC HCC)

Annual reports of the SA HCSCC and the NSW HCCC from 2009, and the Victorian HCC from 2018, were accessed and relevant complaints data was extracted.

Professional bodies

Three peak naturopathy professional bodies were invited to provide relevant, de-identified data concerning complaints reported to their associations. They were:

- ARONAH (a voluntary registering organisation)
- Complementary Medicine Association (CMA) and
- Naturopaths and Herbalists Association Australia (NHAA)

Education providers

Two providers of degree level naturopathy training programs – Endeavour College of Natural Health and Torrens University Australia – were invited to provide information on adverse effects of herbal and nutritional medicines included in naturopathy degree curriculum materials.

3.3 TYPES OF RISK ASSOCIATED WITH NATUROPATHIC AND WHM PRACTICE

The literature provides extensive references on the risks associated with naturopathic and WHM practice and various approaches to classifying risk of harm to public health and safety (Lloyd et al., 2021; Weir 2016; Lin et al., 2005; Wardle & Adams 2014).

Table 3.1 presents a schema for classifying the risks identified in the practice of naturopathy and WHM, modified from the Lin Report (2005). Risks of harm relate to:

- the treatment modalities used by practitioners of naturopathy and WHM
- their scope of practice, and
- their context of practice

Risks associated with the treatment modalities are further categorised as:

- risks that arise from the consumption of nutritional and herbal medicines
- risks associated with the exercise of clinical judgement by the naturopath or herbalist

These categories overlap to the extent that it is common for reported cases to raise multiple practice issues that fall into more than one category.

Table 3.1: Schema for classifying risks associated with the practice of naturopathy & WHM

CATEGORY OF RISK	SUB-CATEGORY	EXAMPLES
Clinical judgement of the practitioner	Acts of commission	• Removal of therapy • Incorrect prescribing
	Acts of omission	• Missed or misdiagnosis • Failure to refer on appropriately • Failure to explain precautions • Failure to advise of known potential adverse effects of a treatment
Unethical and/or criminal conduct		• Pretending to be a qualified practitioner • Sexual assault, sexual misconduct, inappropriate relationship with a patient • Advice to cease or delay conventional treatment • Creating an unreasonable expectation of beneficial treatment outcomes • Undermining public health messaging • Overservicing • Financial exploitation of a patient
Consumption of herbal and nutritional medicines	Predictable toxicity – Type A reactions	• Direct overdosage • Interactions between herbal medicines • Interactions with pharmaceutical medicines
	Unpredictable reactions – Type B reactions	• Allergy/anaphylaxis • Idiosyncratic reactions
	Failure of good handling and manufacturing	• Misidentification • Lack of standardisation • Contamination • Substitution

Source: Modified from Lin et al., 2005.

Table 3.2 expands this categorisation, providing further detail of the risks and referencing related studies and case reports.

Table 3.2: Risks to public health and safety associated with the practice of naturopathy and WHM

RISKS ARISING FROM CONSUMPTION OF HERBAL AND NUTRITIONAL MEDICINES	
Type of risk	**Description**
Adverse reactions / interactions	Poor prescribing of treatments for the patient's condition. Failure to observe contraindications and consider known interactions between herbal medicines and pharmaceutical medicines. Failure to correctly investigate concurrent medication use of patients, consider the potential for interactions with medications or other naturopathic treatments e.g. use of *Glycyrrhizin* species in patients with hypertension. Lack of awareness/attention to potential contraindications and appropriate dosage. Failure to adequately monitor patient use of treatments for reactions (Wardle 2008b; Wardle & Adams 2014). Effects range from minor to severe. Mild adverse effects include allergic reactions, pain, burning sensation, constipation, dermatitis, diarrhoea, dizziness, drowsiness, fatigue, gastrointestinal upset, headache, sleep disorders, nausea, and vomiting. More severe effects include blurred vision, confusion, dysphagia, severe nausea, EEG changes, loss of consciousness, acute lung injury, renal failure, coagulation abnormalities, hepatitis, stroke, acute myocardial infarction, haemorrhage, circulatory failure, congestive heart failure, perforation of the gastrointestinal tract, seizures and epilepsy, and death (Posadzki et al., 2013).
Incorrect prescribing, incorrect treatment duration, or unnecessary testing	Prescribing insufficient doses/products or greater than necessary doses/products, inappropriate duration of treatment, or the unnecessary utilisation of diagnostic tests (Wardle & Adams 2014). Failure to adhere to prescribing guidelines for appropriate dosing for children, teenagers, and smaller / larger adults. Inadequate monitoring of liver/kidney function with prolonged use of some herbs. Inefficacy of treatment, overdosing or toxicity of treatment, inadequacy of treatment, testing with no/little patient benefit, financial harm. Statutory practice guidelines for testing, and scalable dosage prescriptions.
RISKS ASSOCIATED WITH THE CLINICAL JUDGEMENT OR UNETHICAL CONDUCT OF THE PRACTITIONER	
Type of risk	**Description**
Missed or misdiagnosis	Failure to appropriately diagnose patient condition requiring referral to other health practitioner (Wardle 2008). Failure to detect significant underlying pathology, thereby increasing morbidity by allowing a disease process to progress. Poor case taking, inadequate knowledge of pathology or acknowledgement of limitations of practice, leading to inappropriate treatment rather than referring to another practitioner. May result in death, deterioration or relapse of conditions that may have been cured or achieved a better prognosis with earlier intervention.
False diagnosis	Diagnosing patients with non-existent pathologies (Wardle & Adams 2014). Taking advantage of information asymmetries to 'diagnose' and 'treat' fictitious or non-existent pathologies. Exposes patients to unnecessary treatment, stress and expense.
Advice to cease or delay conventional treatments	Informing patients to forego conventional treatment when commencing naturopathic treatment (Wardle 2014: 357). Prescribing a herbal formula for conditions e.g. hypertension and advising the patient to cease taking medically prescribed pharmaceuticals. Immediate withdrawal of pharmaceutical medications can be dangerous and can lead to rebound hypertension. Recommendation to avoid chemotherapy or other cancer treatments.
Delayed diagnosis	Failure to diagnose serious medical conditions or to recognise limitations of own practice skills and knowledge, and when to refer to other health practitioner (Wardle 2008b; Wardle & Adams 2014). Condition incorrectly diagnosed and practitioner assumes treatment will be effective. May result in death, deterioration or relapse of conditions that may have been cured or achieved a better prognosis with earlier intervention.
Failure to refer on in a timely manner	Failure to know when to refer to other health practitioners, e.g. atypical myocardial infarction or cancer not detected or referred to medical practitioner. May result in death, deterioration or relapse of conditions that may have been cured or achieved a better prognosis with earlier intervention.
Monopolisation of patient	Practitioners abusing their position of authority to monopolise patient care for financial gain. Informing patients that all their health needs can be satisfied by the practitioner and discouraging them from seeing their GP or other relevant health professional. May result in financial exploitation, delayed diagnosis or failure to effectively treat serious conditions.
False consultations (by unqualified person purporting to be a naturopath)	Consumer mistakenly believes they received advice from a qualified naturopath (Wardle 2008b). Consumer attends a private practice, a multidisciplinary clinic, pharmacy, or health food store seeking advice from an untrained or inadequately trained person. Consumers may be inappropriately advised to commence or cease treatment, take products that may interact with medication due to not taking an adequate history of the patient, may be prescribed products that are dangerous, or lack quality control in their manufacture, or be prescribed products that are contraindicated in pregnancy Serious herb-drug interactions may occur including concurrent use of anti-depressant medications and commonly used herbal products, potentially leading to serotonin syndrome leading to severe reactions and even death. Patients have become gravely ill or died from ceasing lifesaving medications, such as insulin or ceasing lifesaving medical therapies, such as kidney dialysis as advised by unqualified practitioners.

Undermining public health messaging	Failure of practitioner to follow public health guidelines in their assessment and treatment of patients. Giving patients contrary advice to that provided by health officials. Discouraging patients from vaccinating themselves, their children and families.
Creating an unreasonable expectation of beneficial treatment	Persisting with the use of naturopathic treatments for serious injuries or conditions despite lack of improvement and for which immediate conventional treatment is required (Mackinnon, 2008).
Overservicing	Prescribing treatments for financial gain rather than patient need. Lack of separation between treatment prescription and product sale, as exists in conventional GP consultations, incentivises unscrupulous practitioners to overservice patients (Wardle, 2014).
Lack of informed consent	Failure of practitioner to adequately inform patients of the potential risks of or precautions associated with treatment (Lin et al., 2005: 33-34) (Wardle & Adams 2014). Failure of practitioner to fully inform patients of the risks of naturopathic prescriptions during chemotherapy to deal with adverse effects of conventional treatment. Inefficacy of conventional treatment where there may have been a reasonable expectation of remission.
Holding out as qualified practitioner	Use of the title doctor without appropriate qualifications (Wardle & Adams 2014) Professing to be a naturopath without adequate training. Inappropriate use of the title of doctor lends false legitimacy. Patient believes they are consulting with a qualified practitioner when they are not. Patient is of the mistaken belief that the practitioner is more qualified than they actually are and entrusts their health to someone who is inadequately trained for the task potentially leading to adverse health outcomes.
Sexual assault, sexual misconduct, inappropriate relationship with patient	Sexual misconduct was the most common category of misconduct established against unregistered health practitioners. (Wardle, 2014: 361). This includes inappropriate consensual relationships with patients as well as inappropriate, nonconsensual sexual contact or harassment of a patient. Inappropriate questioning, touching or relationships with patients of a sexual nature with children or adults. Poor understanding of professional boundaries can lead to emotional, physical and fiscal harm through exploitation and manipulating power dynamics between clinician and patient.
Financial exploitation of patient	Consumers taken advantage of financially by unscrupulous practitioners (Wardle 2008b; Wardle & Adams 2014). Consumer is sold an inferior product/s with dubious efficacy, safety, or reliability. Consumer is overcharged for product/s and/or consultation or sold products/ services for financial gain rather than patient need. Financial harm, particularly in diagnoses such as cancer where patients may cling to false hopes of cure

FACTORS ASSOCIATED WITH THE CONTEXT OF PRACTICE THAT EXACERBATE RISK	
Factor	**Description**
Solo and self-employed practice	A provider may be a sole practitioner, with limited peer engagement or oversight with potentially no connection to a professional association through which their practice knowledge and skills may be maintained and assured (NSW HCCC 2019: 33). Practitioner works alone with no or few opportunities to discuss patient cases with peers, discuss difficult to treat cases or consider other modes of treatment or referral (Foronda et al., 2016; Lamb et al., 2011; O'Daniel & Rosenstein 2008). Lack of clinical oversight or other scrutiny increases the likelihood that poor practice or unethical conduct continues undetected, including: ineffective patient treatment, over / underservicing, financial or other exploitation, boundary violations.

3.4 RISKS ASSOCIATED WITH THE TREATMENT MODALITIES OF NATUROPATHS AND HERBALISTS

Any pharmacologically active agent that has the capacity to change human physiological function can also have adverse effects (Lin et al., 2005: 37). Like pharmaceuticals, herbal medicines can trigger two types of reactions:

- **predictable (Type A) reactions:** extensions of the pharmacological effects, generally dose-dependent, and usually less severe; and
- **idiosyncratic (Type B) reactions:** not predicted by pharmacology, occur infrequently, are not related to dose, and can cause significant morbidity or death.

Within the broader research community there has been increasing focus on the adverse effects associated with herbal and nutritional products. The chart below shows the exponential growth in published research from a single database (Ovid MEDLINE) on adverse effects, using general herb and supplement terms (see **Figure 3.1**).

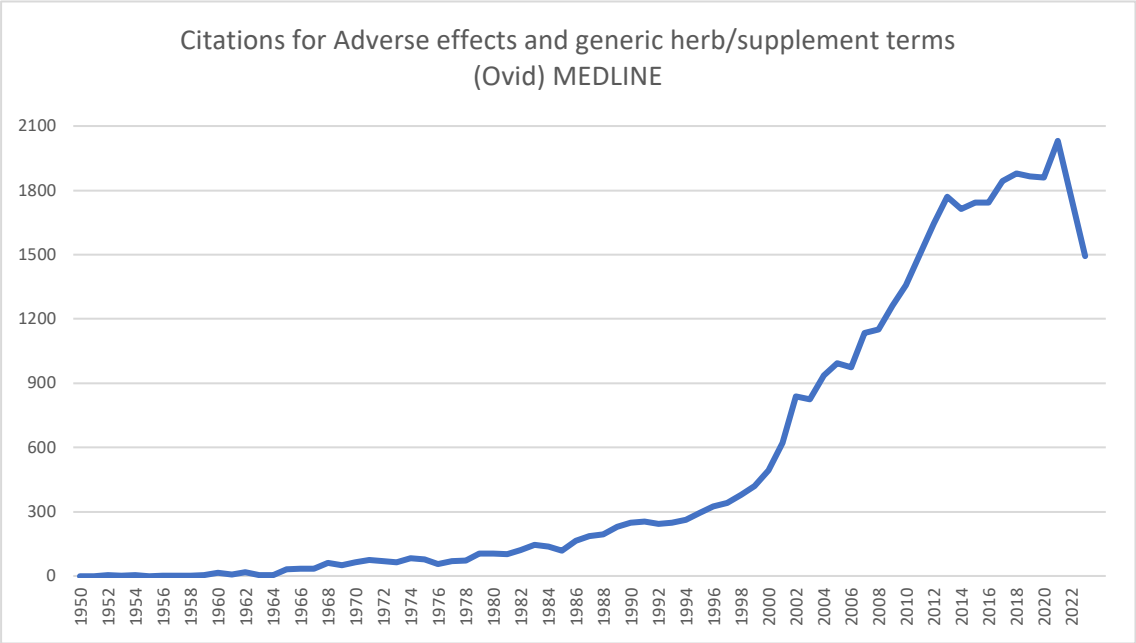

Figure 3.1: Results of bibliometric analysis of adverse effects & 'herb'/'supplement' terms

Unpredictable and idiosyncratic reactions to treatments can and do occur. These adverse events are particularly relevant to naturopaths and herbalists who prescribe and dispense ingestible medicines. They include unpredictable allergic and idiosyncratic reactions to herbs and nutritional supplements (Bensoussan & Myers 1996: 56). They may also involve the failure of good handling and manufacture of CM medicines (Bensoussan & Myers 1996: 56) of which the practitioner may or may not be aware. Cases of misidentification of herbal medicines, lack of standardisation, contamination with heavy metals/toxins, substitution of other herbs or adulteration with Western pharmaceuticals have been documented (Bensoussan & Myers 1996: 56; Foroughi et al., 2017; Opuni et al., 2023; Zhang et al., 2012).

Some herbs and supplements are known to cause toxic reactions and while severely toxic substances are restricted by current drugs and poisons laws, several potentially toxic substances continue to be available to naturopaths/WHM practitioners for use in prescriptions (Asif, 2012; Brown, 2017; Brown, 2018; Enioutina et al., 2017; Posadzki et al., 2013).

Herbal medicines also have the potential to interact with pharmaceutical drugs (Gurley et al. 2012), and numerous cases of such herb-drug interactions have been reported (Choudhury et al., 2023; Izzo & Ernst, 2009; Myers & Cheras, 2004).

The cases identified in the literature are likely to be just a fraction of what is occurring because:

- there appears to be significant under-reporting to government agencies of adverse events associated with nutritional and herbal medicines, due in part to the lack of awareness of the appropriate avenues for such reporting (Choudhury et al., 2023; Yan et al., 2022)
- some practitioners are likely to be fearful that reporting adverse events may result in further withdrawal of access to herbal medicines, and

- the Adverse Drug Reactions database administered by the Therapeutic Goods Administration (TGA) is limited in its usefulness with respect to complementary medicines in that the search function does not include terms such as 'naturopathic medicine' or even 'herbal medicine' (see www.daen.tga.gov.au/medicines-search/)

Risk of harm associated with the treatment modalities used by naturopaths and herbalists may either be mitigated or exacerbated by the level of competence of the practitioner or may be outside of practitioner control. Mitigation of risk is a core component of degree level education for naturopaths and herbalists. For example, in one naturopathy degree program, over 75 resources were identified that are used to educate students on adverse effects and interactions of herbal medicines with pharmaceuticals (see **Chapter 6**, **section 6.7** and **Appendix 6.2**).

3.5 RISKS ASSOCIATED WITH THE SCOPE OF PRACTICE OF NATUROPATHS AND HERBALISTS

Naturopaths and herbalists are primary care practitioners who provide diagnostic and treatment services under a paradigm that differs from that of Western biomedicine.

Like Chinese medicine practitioners, naturopaths and herbalists have a very broad scope of practice – they see patients from every demographic and treat patients with a wide range of health conditions, including those with potentially life-threatening illnesses (Foley et al., 2020; McIntyre et al., 2019; Steel at al., 2020; Steel, 2022). They do this without the need for a referral from a medical practitioner.

Every naturopath and herbalist has a professional obligation to recognise the limits of their practice and to refer on to other practitioners, including medical practitioners, when the needs of the patient dictate. This is an important element of the ethical and clinical training of naturopaths and herbalists. Harm can occur when a naturopath or herbalist fails in the exercise of clinical judgement, either through acts of commission or omission. The risks relate to incorrect, inadequate, or delayed diagnosis, or failure to make timely referrals to practitioners who are better placed to treat the patient. The risks increase when the naturopath or herbalist has received insufficient clinical and ethical training to recognise the limits of their practice and make appropriate referrals.

The Lin Report presented data from a survey of GPs which suggested that while GPs expressed concerns about specific herbal products and interactions, they were also concerned about the scope of practice of naturopaths as well as the specific risks of the therapies used (Lin et al., 2005: 226, 227). Since that survey, there is an increasing body of evidence of serious patient harm and deaths linked to naturopaths and herbalists who have failed in their professional duty to make appropriate and timely referrals (see **section 3.7**).

3.6 RISKS ASSOCIATED WITH THE PRACTICE CONTEXT OF NATUROPATHS AND HERBALISTS

There are several contextual factors that in combination exacerbate the risks associated with naturopathic and WHM practice, compared with other primary care health professions both registered and non-registered. They are:

- the absence of effective controls over entry to practice as a naturopath or herbalist
- the difficulties for patients in identifying who is properly qualified as a naturopath or herbalist and in good standing in their profession
- the challenges faced by patients in navigating two systems of medicine, particularly for those who use naturopathy or WHM in conjunction with Western biomedicine
- the general absence of institution-based quality controls such as those exercised by employers, public sector work settings, and third-party payment systems (health insurers)

First, with the lack of effective controls over entry to practice as a naturopath or herbalist (see **Chapters 6** and **10**), any person can set up practice without qualifications or probity/character checking. There are no enforced minimum entry level credentials, that is, no minimum standard of education that is required for clinical practise as a naturopath or herbalist and no checking to ensure the person is of good character prior to their commencing practice.

This heightens the risk to service users because:

- as outlined above, naturopaths and herbalists have a very broad scope of practice – they treat patients from all age groups who have a wide range of acute and chronic health conditions, using treatment modalities that carry inherent risks
- naturopaths and herbalists do not have access to the range of diagnostic tools that are available to practitioners of Western biomedicine
- untrained or undertrained persons are less likely to recognise the limits of their skills and knowledge and know when to refer on to other practitioners
- misdiagnosis and inadequate treatment are more likely to occur where:
  - clinical training hours are inadequate
  - there is inadequate exposure during training to a range of patients and health conditions

- there is lack of access to training and guidelines on the clinical management of patients who use naturopathic medicines in conjunction with pharmaceutical drugs

Recent cases show the harms that have occurred from unqualified persons who flout professional values and norms by establishing themselves in practice without industry-recognised qualifications and who present themselves as qualified to practise naturopathy or WHM (see **section 3.7**). The data shows a pattern of harm, extending over several decades, arising from those who take advantage of the good reputation of the naturopathy and WHM professions, taking the opportunity to 'make a quick buck'.

This evidence suggests that those who enter practice without recognised training or qualifications are more likely to disregard other ethical norms and standards of professional practice. For instance, some have used the opportunities presented by their practise as a (self-proclaimed) naturopath to breach the trust of their patients by committing sexual assault.

Media coverage of these cases (see **Table 3.3**) often refers to these unqualified persons as 'naturopaths' – because this is the professional title they have assumed for themselves. However, most of these practitioners who come to the attention of regulators due to unethical or illegal conduct are not qualified naturopaths – they may have done short courses or may have no qualifications at all. Some have been deregistered from an NRAS-regulated health profession and have rebadged their practice to avoid the sanctions of the regulator. They have traded on the reputation of and trust in the naturopathic profession to exploit vulnerable patients.

Table 3.3: Selection of media releases and news coverage of cases of harm and calls for stronger regulation of the naturopathy profession

Date	Source/type	Description
Sept 2022	ARONAH Media Release	Calls for registration of naturopaths highlighted on SBS Insight Program
Jun 2022	ABC News	Perth naturopath Rodrigo Bascunan Cabrera jailed for abusing women after bogus diagnoses
Apr 2022	ABC News	Perth naturopath Mauricio Bascunan Cabrera handed a six-year jail term for abusing 18 patients
Nov 2021	ARONAH Media Release	Registering naturopaths is urgently needed to protect the public as a purported "naturopath" is found guilty of sexually assaulting 18 women
Aug 2021	Nine News	Adelaide Hills naturopath suspended from providing COVID-19 advice after publishing anti-vax piece
Aug 2021	ARONAH Media Release	Naturopath comes under investigation for advice on COVID-19 vaccinations
Dec 2020	ARONAH Media Release	Urgent call for Government registration of naturopaths to protect the public
Jun 2020	ARONAH Media Release	Why do we need Registration/Regulation of the Naturopathic profession in Australia? Guest post from the ANC
Apr 2018	ABC News	Naturopath jailed for at least seven months for role in starving infant
Apr 2018	ARONAH Media Release	Government delaying registration of naturopaths exposes public to ongoing risk
Aug 2017	ARONAH Media Release	Delays in statutory registration of naturopaths exposes public to ongoing risk
Jun 2016	ARONAH Media Release	Naturopathy can be safe and effective but registration is the key
May 2016	Sydney Morning Herald	Herbalist declared risk to public after claiming his remedies would cure cancer
Jul 2015	The Guardian	Sydney naturopath arrested after baby comes close to death on treatment plan
Feb 2015	ARONAH Media Release	Dodgy naturopathy courses putting public at risk
Oct 2010	ARONAH Media Release	National register of naturopaths and herbalists to improve public safety
Oct 2010	ABC News	Unregulated naturopaths putting lives at risk.
Jul 2010	ABC News	Incompetent care led to Dingle's death
Oct 2008	Sydney Morning Herald	Sex assault naturopath jailed
April 2008	Sydney Morning Herald	Naturopath banned for life
Apr 2005	ABC News	Naturopath's qualifications unverifiable, inquest told
Sept 2002	The Age	Call for control on alternative medicine

Second, compounding these problems, there is no single trusted source of information for prospective patients about who is qualified as a naturopath or herbalist and in good standing in the profession. Instead, there are multiple professional associations that compete for members, all claiming to represent 'qualified' naturopaths and herbalists but each setting different qualification standards for membership and providing differing levels of service to members and to the public (see **Chapter 7**). This adds to the confusion for prospective patients.

These multiple professional bodies with their varying standards add to the information asymmetry faced by consumers who are likely to struggle to know who is properly qualified as a naturopath or herbalist and who is not.

Third, since most naturopaths and herbalists work autonomously, that is, in independent private practice rather than as an employee or in a public or funded sector agency, the quality controls that usually apply in these latter settings (such as employment contracts, clinical governance systems, supervision, risk audit, performance appraisal, continuing professional development (CPD) etc) are absent.

Also, with the removal in 2019 of naturopathic and WHM services from eligibility for rebates under the Australian Government's *Private Health Insurance Rules*,[17] there are no institutional quality control measures applied by third-party payers (insurers) either (see **Appendix 3.2**). This means there are no public or private health insurers to assess the qualifications of practitioners, set practice expectations, scrutinise claims data and alert regulators to professional practice or clinical governance failures

17 See Private Health Insurance Rules.

such as incompetent practice, overservicing, or fraud (see Chapter 8).

Fourth, for those who use both naturopathic medicines and pharmaceutical drugs, there are heightened risks associated with herb/drug interactions. These risks are exacerbated by the inability of the profession to enforce minimum qualification and practice standards for the clinical management of patients who use naturopathic medicines in conjunction with pharmaceutical drugs, and the general lack of communication among the various providers.

As more people with chronic health conditions choose naturopathic or WHM treatment, the potential for herb/drug interactions increases. There is evidence that many patients do not tell their treating medical practitioners of their use of naturopathic medicines (see Chapter 2 and Textbox 3.1).

Textbox 3.1: Findings from the Lin Report on risks associated with naturopathic and WHM treatments

- the majority of patients self-refer following recommendation from another person
- treatment is sought for a wide range of physical and psychological problems, and management is multifaceted (including lifestyle advice, nutritional supplements, herbal medicines and exercise)
- those seeking naturopathic care frequently do so for chronic conditions, which means they are likely to be frequent and routine users
- approximately half the profiled patients had previously consulted a medical practitioner (general or specialist) for their complaints before visiting a naturopath, but communication between practitioners occurred in only a minority of cases
- among the profiled patients receiving naturopathic treatment, over one third were also taking pharmaceutical drugs
- focus group participants reported that they did not advise their doctor of their use of naturopathic medicines because they feared the doctor might reject the therapy or because they felt they should be in charge of their health
- poor communication between medical and complementary medicine practitioners can have dangerous consequences in terms of drug interactions and delayed diagnosis

Source: Lin et al., 2005: 294-95

More recent data suggests these risks remain (Doolan 2024) and are compounded by the variability in education and training of naturopaths and herbalists (see Chapter 6). Those who enter practice with inadequate or no qualifications or clinical training are less likely to have the capacity or motivation to keep up to date with the exponential growth in naturopathic and WHM research, they are less likely to be engaged with their peers in scholarly collaboration, or to adopt evidence-based naturopathic practice. They are also less likely to collaborate with practitioners from other professions in shared care of patients.

3.7 COMPARISON OF RISK PROFILES OF NATUROPATHY AND THE REGULATED PROFESSIONS

This study identified various approaches and tools for measuring risk, including some developed specifically to inform decisions about occupational regulation of the health professions (Professional Standards Authority, 2016; AHMAC, 2013; COAG Health Council, 2015).

One risk assessment tool used in several Australian inter-governmental reports (AHMAC 2013; COAG Health Council 2015) lists 13 'high-risk activities' (HRAs) and identifies whether or not these high-risk activities form part of the usual scope of practice of each profession that is rated. The high-risk activities listed span both scope of practice (including the treatment modalities) and the context of practice.

Appendix 3.3 provides details of the HRAs included in the naturopathic scope of practice. They are:

- Putting an instrument, hand or finger into a body cavity (HRA 1)
- Procedures below the dermis, mucous membrane, in or below the surface of the cornea (HRA 4)
- Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses drugs (HRA 5)
- Administering a substance by injection (HRA 6)
- Supplying substances for ingestion (HRA 7)
- Managing labour or delivering a baby (HRA 8)
- Primary care practitioners who see patients with or without a referral from a registered practitioner (HRA 11)
- Treatment commonly occurs without others present (HRA 12)
- Patients commonly required to disrobe (HRA 13)

Table 3.4 applies this risk assessment tool to compare the risk profile of the naturopathy profession with those of the 16 health professions that are regulated under the NRAS. Of the 13 HRAs listed, the scope of practice of naturopathy profession typically includes at least **nine (9)** of these activities. This is high, compared with most NRAS-regulated health professions, which range from three HRAs (optometrists and psychologists) to 13 HRAs (medical practitioners). Only five out of 16 of the NRAS-regulated health professions have a higher number of HRAs as part of their usual scope of practice than naturopaths. They are: medical practice (13 HRAs), nursing and midwifery (11 HRAs), paramedicine (10 HRAs) and Chinese medicine (10 HRAs).

While prescribing a scheduled medicine is listed as part of the usual scope of naturopathic practice, there is currently no mechanism under Australian state or territory drugs and poisons laws to authorise practitioners of naturopathy/WHM to prescribe herbal medicines that have been included in *The Poisons Schedule* (either as a whole herb or because of a substance the herb contains).

Appendix 3.4 provides a list of herbs that some (but not all) naturopaths and WHM practitioners are trained to prescribe but have been restricted under Australian scheduling arrangements and may only be prescribed by registered medical practitioners (Lin et al., 2005: 109). These herbs are listed in the British and US herbal pharmacopoeias and are typically used by naturopaths in countries where naturopathy is widely practised. Others have been added to the Poisons List since 2005.[18]

18 See the Poisons List (the SUSMP) at https://www.tga.gov.au/how-we-regulate/ingredients-and-scheduling-medicines-and-chemicals/poisons-standard-and-scheduling-medicines-and-chemicals/poisons-standard-susmp

Table 3.4: Risk assessment – naturopathy profession compared with NRAS-regulated professions

	HIGH-RISK ACTIVITIES	Regulated	ABORIGINAL & TORRES STRAIT ISLANDER HEALTH PRACTITIONERS	CHINESE MEDICINE PRACTITIONERS	CHIROPRACTORS	DENTAL PRACTITIONERS	MEDICAL PRACTITIONERS	MEDICAL RADIATION PRACTITIONERS	NURSES & MIDWIVES	OPTOMETRISTS	OCCUPATIONAL THERAPISTS	OSTEOPATHS	PARAMEDICS	PHARMACISTS	PHYSIOTHERAPISTS	PODIATRISTS	PSYCHOLOGISTS	Unregulated	NATUROPATHS
PRACTICE SCOPE	1. Putting an instrument, hand or finger into a body cavity[i]		✗	✗		✗	✗		✗				✗		✗				✗
	2. Manipulation of the spine[ii]			✗	✗		✗					✗			✗				
	3. Application of a hazardous form of energy[iii] radiation					✗	✗	✗	✗		✗				✗				
	4. Procedures below dermis, mucous membrane, in or below surface of cornea or teeth		✗	✗		✗	✗	✗	✗				✗			✗			✗
	5. Prescribing a scheduled drug (incl. compounding), supervising that part of a pharmacy that dispenses scheduled drugs		✗	✗		✗	✗		✗	✗			✗	✗		✗			✗
	6. Administering a scheduled drug or substance by injection		✗	✗		✗	✗	✗	✗				✗	✗		✗			✗
	7. Supplying substances for ingestion		✗	✗			✗		✗				✗	✗					✗
	8. Managing labour or delivering a baby			✗			✗		✗				✗						✗
	9. Undertaking psychological interventions to treat serious disorders or with potential for harm						✗		✗				✗				✗		
	10. Setting or casting a fracture of a bone or reducing dislocation of a joint						✗												
CONTEXT	11. Primary care practitioners who see patients with or without a referral from a registered practitioner		✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗	✗		✗
	12. Treatment commonly occurs without others present[iv]		✗	✗	✗		✗	✗	✗	✗	✗	✗	✗		✗	✗	✗		✗
	13. Patients commonly required to disrobe		✗	✗	✗		✗	✗	✗		✗	✗	✗		✗				✗
	TOTAL risk factors by profession		8	10	4	6	13	6	1	3	4	4	10	4	6	5	3		9

Notes

i. Beyond the external ear canal, beyond the point in the nasal passages where they normally narrow, beyond the larynx, beyond the opening of the urethra, beyond the labia majora, beyond the anal verge, or into an artificial opening in the body.

ii. Moving the joints of the cervical spine beyond the individual's usual physiological range of motion using a high-velocity, low-amplitude thrust.

iii. Electricity for aversive conditioning, cardiac pacemaker therapy, cardioversion, defibrillation, electrocoagulation, electroconvulsive shock therapy, electromyography, fulguration, nerve conduction studies or transcutaneous cardiac pacing, low frequency electromagnetic waves/fields for magnetic resonance imaging and high frequency soundwaves for diagnostic ultrasound or lithotripsy.

iv. Includes practitioners who practise solo or treat with no others present, such as medical specialists and practitioners who may be solely responsible for clinical care overnight or in a remote community.

v. Paramedics included as per indicative assessment made in AHMAC *Final report: Options for regulation of paramedics (2016).*

Source: Modified from AHMAC 2015: 110-11.

3.8 HOW THE RISKS HAVE BEEN REALISED IN PRACTICE

The risks described above are not just theoretical. Table 3.5 presents a selection of high-profile cases where naturopaths (or those claiming to be naturopaths) have been prosecuted for offences ranging from sexual assault, to making dubious treatment claims and misrepresenting their qualifications, to advising their patients to cease Western biomedicine treatments. Many of these individuals have had insufficient training (or none) and would not be eligible to practise as a naturopath or WHM and to use those professional titles if there were a legal mechanism to enforce minimum entry level qualification and probity standards.

Many of the most egregious cases of incompetence or unethical conduct are associated with unqualified practitioners who have assumed the title 'naturopath'. There is also evidence of recidivism by practitioners who have been deregistered (from another profession) or issued with a prohibition order (PO) by a state or territory health complaints entity (HCE) (see cases of Bodnar, Brophy, Jarvis, O'Neill, Pile and Zaphir).

These cases have been drawn from various sources including disciplinary proceedings or decisions from health complaints entities and tribunals, coronial inquests, consumer affairs and fair-trading regulatory actions, civil and criminal proceedings, and some media reports. However, determining the prevalence of serious misconduct by naturopaths and WHM practitioners (or those falsely claiming to be a naturopath) is complex. There is insufficient data available to estimate with any confidence the underlying rate of misconduct, the rate at which misconduct is reported to regulators and tribunals, or the outcomes, that is, how regulators and tribunals act on such reports (Elkin 2011: 455).

Table 3.5: Misconduct by individuals identifying as naturopaths or using naturopathic modalities (WHM, nutrition)

NAME	NATURE OF CONDUCT	MEDIA COVERAGE
Mauricio Bascunan Cabrera AND Rodrigo Bascunan Cabrera	Mauricio Cabrera, a **self-proclaimed naturopath** from Perth was convicted of sexually assaulting nineteen women between 2010 and 2017. Rodrigo Cabrera, a **self-proclaimed naturopath** from Perth was convicted of sexually assaulting six women after giving them false diagnoses	Registration of naturopaths is urgently needed to protect the public Perth naturopath Mauricio Bascunan Cabrera handed six-year jail term for abusing 18 patients Naturopath Mauricio Bascunan Cabrera guilty of indecently assaulting 18 female patients Perth naturopath Rodrigo Bascunan Cabrera jailed for abusing women after bogus diagnoses
Marilyn Bodnar	Marilyn Bodnar, a **self-proclaimed naturopath** from NSW was acquitted of manslaughter of a 42-year-old woman who died after Bodnar had placed her on a 63-day water-only fast in 1986. In 2018 Bodnar entered a plea of guilty and was convicted for failing to provide for a child causing danger or death. This was due to her advising a breastfeeding mother to undertake a raw food-only diet to treat her infant's eczema. When the child was admitted to hospital he was in a critical condition, within days of death and suffered significant developmental delay. Although permanently prohibited from providing any health services, Bodnar was convicted in 2022 for breaching this lifetime ban.	Public Statement and Statement of Decision in relation to Ms Marilyn Bodnar Naturopath jailed for at least seven months for role in starving infant Naturopath jailed after baby nearly starved to death Convicted naturopath Marilyn Bodnar issued permanent prohibition order by NSW HCCC Naturopath involved in baby's near death in court for giving advice
Robert Jarvis	Robert Jarvis, a **de-registered chiropractor practising as a naturopath** was issued with a PO by the NSW HCCC for three years for asking inappropriate questions regarding a female client's sexuality, touching the patient's breasts and failing to have appropriate professional indemnity in place. Jarvis breached this PO and was issued with a permanent prohibition order (PPO) after he inappropriately touched and spoke to a young woman in a meditation class.	Meditation instructor banned over opportunistic physical contact Mr Robert Jarvis – permanently prohibited from providing any health services
Sean Kirsten	A PO was issued by the NSW HCCC against Sean Kirsten, a **self-proclaimed nutritionist** for two years for claiming to be an expert in nutrition and treating people with complex medical and mental health conditions with a $2000 12-week program. He advised one client to stop taking antidepressant medication she had been taking for three years without consulting her treating doctor. He held himself out as willing or able to cure cancer.	HCCC Public Statement in relation to Sean Kirsten Fake dietitian and nutritionist Sean Kirsten sanctioned by HCCC
Aleksander Strande	The NSW HCCC issued a PPO against Aleksander Strande, a **naturopath** who had wilfully misrepresented and overstated the level of his qualifications and made claims about the efficacy of treatments which could not be substantiated. He lacked knowledge to determine whether the products he prescribed may have adverse reactions with their prescribed medications. He failed to provide information to clients regarding the herbal medicines and pressured his clients to continue treatment with him despite complaints of adverse side effects. He was not willing to seriously reflect on his practice and has no insight into the limitations of his training and qualifications and his competence to treat serious illnesses.	Shonky naturopaths claimed to cure cancer: banned for life, still advertising Mr Aleksander Strande – breaches Code of Conduct – permanent prohibition order Public Statement and Statement of Decision in relation to Mr Aleksander Strande
Barbara O'Neill	The NSW HCCC issued a PPO against Barbar O'Neill, a **self-proclaimed naturopath** for making dubious and dangerous health claims regarding infant nutrition, causes and treatment of cancer, antibiotics and vaccinations that are not evidence-based or supported by mainstream medicine. Despite the PPO banning O'Neill from providing any health education services, she has a large social media following, around 1.3 million followers on Facebook, showcasing her health education services, where she is now referred to as Dr Barbara O'Neill, despite holding few, if any health qualifications.	Public Statement and Statement of Decision in relation to Mrs Barbara O'Neill Dr Barbara O'Neill Facebook profile
Wayne Leibelt	The South Australian Health Complaints Commissioner issued Wayne Leibelt, a **naturopath** with a PO indefinitely prohibiting him from providing health education or information related to COVID vaccinations or advice in relation to COVID vaccinations. The order followed an article he wrote that was published in an Adelaide newspaper which contained claims that were false and misleading. He was not trained or qualified to provide information about COVID 19 vaccines and had based his claims on non-peer reviewed opinion and speculation.	Naturopath comes under investigation for advice on COVID-10 vaccinations Public Statement: Prohibition Order – Mr Wayne Leibelt Naturopath's indefinite Covid ban over opinion piece in local newspaper

NAME	NATURE OF CONDUCT	MEDIA COVERAGE
Ian Pile	The NSW HCCC issued a PO against Ian Pile, a **Western herbalist** for advising a client with metastatic bowel cancer and a colostomy bag that by taking his prescribed herbs her cancer would be 'cured in a couple of weeks.' Pile provided the client with herbs with emetic properties that caused her to vomit soon after taking them. He used the herb Bloodroot in a capsule when it is restricted to topical use in Australia. He gave liver detoxifying herbs to a client with liver metastases and failed to monitor or request tests of liver enzymes. He failed to confer with the patient's orthodox treating practitioner. He failed to demonstrate a sound understanding of any adverse interactions. He held himself out as qualified, able, or willing to cure cancer and failed to maintain accurate and contemporaneous clinical records. He also failed to ensure that appropriate indemnity insurance arrangements were in place. After the PO was issued in NSW, Pile relocated to SA and was issued with another indefinite PO for offering health services in the Mt Gambier area and distributing bittersweet almond capsules (containing a dangerous chemical – prussic acid that can cause cyanide poisoning) and asserting its efficacy in fighting cancer.	Public Statement and Statement of Decision in the matter of Ian Pile Herbalist declared risk to public after claiming his remedies would cure cancer Indefinite Prohibition Order against Mr Ian Pile
George Zaphir	An interim prohibition order (IPO) was issued by the Qld Health Ombudsman (HO) against George Zaphir, a **deregistered chiropractor practising as a natural therapist**, for leading patients to believe that he could cure cancer with black salve and Vitamin C injections. Zaphir failed to appropriately refer on patients to other health practitioners when their condition did not improve. He plead guilty to 56 counts of breaching the prohibition order and was convicted and fined $30,000 in 2019.	George Zaphir (former chiropractor) prohibition order Disgraced chiropractor who claimed to 'cure cancer' fined $30k
Diedre Brophy	The Qld Health Ombudsman issued an IPO against Deidre Brophy, a **natural therapist**, prohibiting her from providing any health services including thermal imaging, diagnosing illness, and the manufacture, advice, or supply of black salve, or any naturopathy service. Brophy contested 5 counts of contravention of the order and was found guilty on 3 counts and ordered to pay a fine of $5,000.	Deidre Brophy (health care worker) prohibition order Tablelands woman who invented and sold 'cancer treatment' online dealt with by court
Jeffrey Dummett aka Jeremiah Hunter	Jeffrey Dummett, a **self-proclaimed naturopath** from NSW was acquitted of manslaughter of a patient – a 39-year-old man with chronic kidney disease, who died after undergoing a 10-day detoxification program with Dummett. The man had ceased prescribed kidney dialysis four times a day and other medication to undergo the program. A postmortem examination found the man had died from a heart attack and had an undiagnosed heart condition.	Naturopath's qualifications unverifiable, inquest told Naturopath found not guilty of patient's death Naturopath not guilty of manslaughter
Michael Morris Wilson	Michael Wilson, a Melbourne **naturopath** was convicted by a jury of the rape and sexual assault of 13 women and 2 children over an 18-year period. He was sentenced to 16 years imprisonment with 12 years to be served.	Naturopath jailed for sexual assaults on patients Sex assault naturopath jailed
Reginald Fenn	Reginald Fenn, a NSW **naturopath** was convicted of the manslaughter of an 18-day-old baby boy with a critical aortic stenosis which could only be treated by surgery. The infant died of heart failure before an operation was carried out. Fenn advised that his herbal drops had cured the baby and, on this advice, the parents cancelled his operation.	Australian naturopath convicted of manslaughter: quack device implicated Naturopath guilty of manslaughter
Melbourne naturopath	The Director of Haematology & Oncology at the Royal Children's Hospital, Melbourne advised he had been contacted by many doctors after he revealed in The Age that a boy with a 60% chance of cancer survival died following his parents' decision to stop chemotherapy. An unnamed Melbourne **naturopath** had advised the parents that an unconventional treatment might offer a cure. But the boy died six months later, three days after his parents returned him to hospital requesting chemotherapy be restarted. The hospital Director advised he was surprised by the number of similar anecdotes from other physicians at the Royal Children's and Royal Melbourne hospitals. The baby, a boy under the age of one, was epileptic and under the care of the Royal Children's Hospital Neurology Department. The hospital's Director of Neurology advised that the family did not want to give the baby conventional medicine because they were also seeing a natural therapist. The infant was having tens of seizures a day while off medication.	Call for control on alternative medicine

Source: Modified from Doolan (2024)

3.9 LANDMARK STUDIES OF THE RISKS ASSOCIATED WITH NATUROPATHIC AND WHM PRACTICE

Two landmark reports, one Australian and one international, have systematically documented the risks associated with the practice of naturopathy and WHM. Details of the findings of these studies are outlined below.

The Lin Report

In 2005, the Lin Report presented an assessment of the risks associated with the practice of naturopathy and WHM. The report formulated a typology of risks, finding that risks fell into two main categories: risks associated with practice, and risks associated with the consumption of herbal and nutritional medicines (2005: 53-4).

In relation to risks associated with naturopathic practice, the researchers found:

- evidence of failures of clinical judgment of practitioners involving both acts of commission and omission
- practitioner-reported adverse events related to herbal medicine and nutritional supplement use, although it was not clear whether these were the result of poor practice (including inappropriate prescribing) or the medicines themselves
- GPs reported severe adverse reactions from complementary and alternative medicine use, although the harms were considered to relate more to the scope of practice of naturopaths than to the therapies themselves
- scope of practice risks were exacerbated by the broad range of patients and conditions treated coupled with lack of recognition by some practitioners of the limitations of their practice, contributing to incorrect, inadequate, or delayed diagnoses (2005: 53)

Risks were associated with naturopaths and herbalists as primary care clinicians consulting on a wide range of health conditions, whose principal tools of trade involve ingestible medicines (Lin et al., 2005: 53).

With respect to the consumption of herbal and nutritional medicines the researchers found:

- herbal and nutritional medicines produce both predictable and unpredictable effects, just as in Western medicine, with cases of both identified
- predictable effects included direct toxicity, overdose toxicity, and toxicity associated with interaction of herbal medicines with pharmaceutical medications
- unpredictable effects include allergic and anaphylactic reactions to herbal medications, and idiosyncratic reactions
- several herbs causing toxic reactions are well-documented, the most toxic of which were restricted by legislation, while a number of less toxic substances are available to practitioners
- herbal and nutritional medicines have the potential to interact with pharmaceutical drugs, and numerous cases were reported
- risks are also associated with inappropriate handling or manufacture of herbal and nutritional medicines, though few examples were found in Australia or overseas
- there was insufficient data to quantify the risks presented by naturopathic or herbal medicines in any detail, nor was it possible to estimate the adverse event rate for herbal and nutritional medicines from case reports and case series alone because the total exposure to a particular medicinal substance was unknown (Lin et al., 2005: 53)

The researchers also reported the results of an Australian workforce survey which estimated that practitioners experience one adverse event every eleven months of full-time practice, and 2.3 adverse events for every 1,000 consultations. Under-reporting was considered of concern, due to practitioners' lack of awareness of reporting avenues (Lin et al., 2005: 54).

The TGA Adverse Drug Reaction Reporting System (ADRS) database was considered of limited usefulness and applicability to complementary medicines and was not being widely utilised by non-registered practitioners. More research was considered necessary to provide a more accurate assessment of the risks. Minimising these risks was identified as a priority for both government and the profession (Lin et al., 2005: 54). The researchers also raised concerns about the changing profile of risk due to factors such as:

- herbal manufacturers using new extraction methods designed to increase the potency of herbal medicines
- patients using naturopathic medicines for an increasingly wide range of illnesses
- patients who use herbal and other naturopathic medicines concomitantly with pharmaceutical drugs (Lin et al., 2005: 55)

The Lin Report concluded that the degree of risk to public health and safety warranted consideration of more effective occupational regulation – to provide enforceable minimum education and clinical practice standards and help reduce the incidence of adverse reactions and improve their management (Lin et al., 2005: 55). The researchers also concluded that the level of risk identified is likely to be underestimated because:

- apparent significant under-reporting to government agencies of adverse events associated with nutritional and herbal medicines, due in part to the

- lack of awareness of the appropriate avenues for such reporting
- some practitioners are likely to be fearful that reporting adverse events may result in withdrawal of access to medicines
- the ADRS database administered by the TGA is limited in its usefulness with respect to complementary medicines
- complaints data held by professional associations are largely about professional issues rather than adverse reactions to medicines (Lin et al., 2005: 292)

They found some evidence to suggest that practitioners occasionally use scheduled herbs which they are not authorised to use, suggesting either a lack of awareness of the legal restrictions that apply to herbal medicines or wilful lawbreaking (Lin et al., 2005: 108).

The World Naturopathic Federation's Health Technology Assessment

More recent data from the World Naturopathic Federation's Health Technology Assessment (HTA) of naturopathy adds weight to the findings of the Lin Report (Lloyd et al., 2021: 71-78). The main findings included:

- Cases of adverse events related to acts of commission (such as recommending cessation of medical treatment or failure to avoid known interactions with pharmaceuticals) and acts of omission (such as misdiagnosis and failure to refer on to an appropriate practitioner) have been reported in the literature and in the media. Although these events do not appear to be widespread, the COVID-19 pandemic has highlighted cases and the potentially serious consequences.
- Like Western pharmaceutical medicines, herbal medicines can produce predictable and unpredictable effects. Examples of both have been identified in the literature. Predictable effects include direct toxicity, toxicity related to overdose of a preparation, and interaction with pharmaceutical medicines. Unpredictable effects include allergic and anaphylactic reactions to herbal medicines, and idiosyncratic reactions (Colalto 2012; WHO 2004).
- A number of herbs and supplements are known to cause toxic reactions and while severely toxic substances are restricted by current drugs and poisons legislation, several potentially toxic substances continue to be available to naturopaths for use in prescriptions (Asif 2012; Brown 2017; Brown 2018; Posadzki et al., 2013).
- Herbal medicines have potential to interact with pharmaceutical drugs (Gurley et al., 2012), and numerous cases of such herb-drug interactions have been reported (Myers & Cheras 2004; Izzo & Ernst 2009).

The WNF HTA also discussed the impacts of the context of practice of naturopaths in its investigation of occupational regulation regimes for naturopaths across 108 countries. Researchers concluded that reliance on voluntary certification of naturopaths by professional associations is problematic when the practices of a health profession present potentially serious risks to public health and safety:

- Where there are no statutory powers to restrict entry to a profession, those with minimal or no qualifications can set up practice and use the titles of the profession without meeting acceptable minimum standards of training and practice. This has led to widely varying standards of practice and levels of qualifications, substantial fragmentation of these professions, and no widely recognised and accepted peak bodies.
- Most professional associations rely on volunteers drawn from the profession and may lack access to the necessary skills, resources, and capacity to handle the complexity associated with effective regulation.
- There are conflicts of interest in the operation of voluntary certification which can compromise public protection, for example where the professional association is responsible for representing its members' interests and at the same time accrediting programs that are tied to membership and dealing with complaints about members.
- Schemes that operate at arms-length from professional associations (such as the governance model adopted by ARONAH in Australia) are often constrained by poor resourcing and policy capacity and as with all voluntary certification, the standards apply only to those practitioners who decide to opt in (Lloyd et al., 2021: 50).

3.10 COMPLAINTS DATA

Complaints can be used as a proxy marker for risk, an indicator of potential public health and safety concerns, in the absence of other forms of reporting or surveillance of either adverse events or professional conduct (Lin & Gillick 2011: A, C). Complaints provide important data about patient risk, harm, and dissatisfaction and have the potential to provide guidance for regulatory and educational intervention (Ryan, Too & Bismark 2018: 2).

However, complaints are an imperfect indicator of quality of care in that most instances of poor performance, impairment, or unethical conduct do not result in a formal complaint (Ryan, Too & Bismark, 2018: 7). One New Zealand study concluded that 'when complaints are set against the underlying rate of injury, it was apparent that they represent only the tip of an iceberg of adverse events' (Bismark et al., 2006: 22).

This section presents data on complaints from state and territory health complaints entities, professional associations and the regulator, ARONAH.

Complaints reported by Health Complaints Entities (HCEs)

The websites of state and territory HCEs were searched for details of complaints about naturopaths, herbalists, and other natural therapists. Most of the data sourced was from the NSW HCCC with some data available from the Victorian HCC.

Number of complaints

Table 3.6 presents the data on the number of complaints brought against naturopaths, herbalists, and other natural therapists in NSW and Victoria.

There were 82 complaints involving naturopaths, herbalists, and other natural therapists reported to the NSW HCCC over a five-year period to 2022, an average of 16 complaints per year. In Victoria, 122 complaints were reported over the five-year period to 2022, an average of 24 complaints per year.

Since 2005, the number and annual rate of complaints against naturopaths, herbalists, and other natural therapists has increased in both NSW and Victoria. Complaints against naturopaths averaged around 2.5 per annum for the first decade of reporting following the introduction of the Code of Conduct and prohibition order powers of the NSW HCCC (2009-2018). In the four years to 2022, complaints against naturopaths in NSW have averaged over 10 complaints per year, a fourfold increase. Reasons for this rate increase are not known but may be due in part to increased awareness of the role and powers of the NSW HCCC to issue prohibition orders.

While the number of complaints lodged about naturopaths with the NSW HCCC has increased between 2009 and 2022, complaints against other natural therapists have been declining. It is not clear whether the shift in numbers between the two practitioner categories is attributable to a reduction in the reporting of natural therapists or more accurate reporting of natural therapists as naturopaths. Also, the number of complaints received in the last five years in NSW about naturopaths and herbalists (n = 44) is almost five times the number of complaints received in Victoria (n = 9) for the same period. While the reasons for this are unknown, it may be due to misclassification in Victoria of naturopaths and herbalists as natural therapists.

Table 3.6: Complaints reported by Health Complaints Entities related to naturopaths, herbalists and other natural therapists

State/Territory	Reporting year ending June	Number of complaints (% of all complaints in brackets for registered and non-registered practitioners)			
		Naturopath	Herbalist	Other natural therapist[19]	Total
New South Wales[20]	2009	2 (0.1)		4 (0.2)	6 (0.3)
	2010	3 (0.1)		7 (0.3)	10 (0.4)
	2011	1 (0.0)	2 (0.1)	20 (0.8)	23 (0.9)
	2012	1 (0.0)		12 (0.5)	13 (0.5)
	2013	6 (0.2)		19 (0.6)	25 (0.8)
	2014	4 (0.1)		13 (0.4)	17 (0.5)
	2015	2 (0.1)		9 (0.3)	11 (0.3)
	2016	3 (0.1)		12 (0.3)	15 (0.4)
	2017	1 (0.0)		14 (0.3)	15 (0.4)
	2018	2 (0.0)	1 (0.0)	8 (0.2)	11 (0.2)
	2019	14 (0.3)		8 (0.2)	22 (0.2)
	2020	8 (0.2)		7 (0.1)	15 (0.1)
	2021	12 (0.2)		8 (0.2)	20 (0.1)
	2022	7 (0.1)		7 (0.1)	14 (0.2)
Total		66	3	148	217
Victoria	2018	8 (0.3)	1 (0.0)	12 (0.4)	21 (0.7)
	2019			32 (1.8)	32 (1.8)
	2020			25 (1.3)	25 (1.3)
	2021			23 (1.5)	23 (1.5)
	2022			21 (1.2)	21 (1.2)
Total		8	1	113	122[21]
ACT		Not available	Not available	Not available	
Northern Territory		Not available	Not available	Not available	
Queensland		Not available	Not available	Not available	
South Australia		Not available	Not available	Not available	
Tasmania		Not available	Not available	Not available	
Western Australia		Not available	Not available	Not available	

19 Includes: alternative therapists, alternative health providers, complementary and alternative practitioners, natural therapists, nutritionists. Excludes: homeopaths, traditional Chinese medicine practitioners, acupuncture therapists, kinesiologists and reflexologists.

20 Given some differences in reporting of data for 2009-2018, data has been extracted from the following reports and does not include other or unknown categories of health practitioners.

21 MISSING FROM SUPPLIED COPY

In 2005, data was reported on complaints from all state and territory HCEs (Lin et al., 2005: 35). However, for this study no disaggregated complaints data was available from the HCEs of ACT, Queensland, Northern Territory, South Australian, Tasmania or Western Australia, compared with the data reported by Lin & colleagues.

Combining five years of complaints data from NSW and Victoria, an average number of complaints per annum was calculated – 41 complaints per year.[22] Extrapolating the combined NSW and Victorian data nationwide (assuming a similar rate of complaints in the remaining states and territories), a nationwide figure was calculated of approximately 72 complaints per annum.

By way of comparison, the number of complaints (notifications) received by Ahpra about registered Chinese medicine practitioners was 76 notifications in 2022 and 33 notifications in 2023 (Ahpra & National Boards Annual Report 2021/22: 13; Ahpra & National Boards Annual Report 2022/23: 15).

Types of complaints

Only the NSW HCCC reports data on the types of complaint by practitioner group.

Table 3.7 presents data on the types of complaints about naturopaths, herbalists, and other natural therapists received by the NSW HCCC over the period 2016-22. Professional conduct, treatment, and communication/information accounted for 89% of all complaints, compared with 71% of complaints to professional bodies (see Table 3.8). Professional conduct was the most common type of complaint against naturopaths, herbalists, and natural therapists, followed by treatment issues. Communication/information and fees and costs were the third and fourth most common types of complaint.

22 NSW and Victoria account for 57.6% of the Australian population. See Australian population distribution by state.

Table 3.7: NSW HCCC Types of complaints about naturopaths, herbalists & other natural therapists

Type of complaint	Number of complaints (% of total complaints for non-registered practitioners)							Total (% of all types)
Type of complaint	2016	2017	2018	2019	2020	2021	2022	
Treatment								48 (26.0)
Naturopath	1 (0.5)		3 (1.6)	6 (2.9)	6 (2.7)	7 (2.2)	3 (1.0)	26
Other natural therapist	3 (1.4)	5 (2.5)	4 (2.1)	3 (1.4)		4 (1.3)	3 (1.0)	22
Professional conduct								84 (45.4)
Naturopath	2 (0.9)	1 (0.5)	3 (1.6)	9 (4.3)	2 (0.9)	7 (2.2)	5 (1.7)	29
Herbalist			1 (0.5)					1
Other natural therapist	12 (5.4)	12 (6.0)	8 (4.2)	2 (1.0)	10 (4.4)	5 (1.6)	5 (1.7)	54
Communication / information:								33(17.8)
Naturopath	1 (0.5)	1 (0.5)		2 (1.0)	3 (1.3)	1 (0.3)	4 (1.4)	12
Other natural therapist	3 (1.4)	2 (1.0)	4 (2.1)	3 (1.4)	4 (1.8)	1 (0.3)	4 (1.4)	21
Fees / costs								13 (7.0)
Naturopath				2 (1.0)	2 (0.9)			4
Other natural therapist	1 (0.5)	3 (1.5)	3 (1.6)	1 (0.5)		1 (0.3)		9
Medication								4 (2.2)
Naturopath			1 (0.5)			1 (0.3)	1 (0.3)	3
Other natural therapist						1 (0.3)		1
Consent								1 (0.5)
Naturopath								
Other natural therapist						1 (0.3)		1
Environmental / management of facilities								1 (0.5)
Other natural therapist						1 (0.3)		1
Reports / certificates								**1 (0.5)**
Other natural therapist	1 (0.5)							
Totals								**185[23]**
Naturopath	4 (1.8)	2 (1.0)	7 (3.7)	19(9.1)	13(5.8)	16(5.1)	13(4.4)	74
Herbalist			1 (0.5)					1
Other natural therapist	20 (9.0)	22 (4.2)	19(10.0)	9 (4.3)	14 (6.2)	14(4.5)	12(4.0)	110
Total	24(10.1)	24(12.0)	27(14.2)	28(13.3)	27(12.0)	30(9.6)	25(8.4)	185[23]

23 Data sources: Data 2015-16 was extracted from HCCC Annual Report, 2015-16 Table A5, 116. Data for 2016-17 was extracted from HCCC 2016-17 Annual Report, Table A5, 141. Data for 2017-18 was extracted from HCCC 2017-18 Annual Report, Table A5, 153. Data for 2018-19 was extracted from HCCC 2018-19 Annual Report, Table A5, 145. Data for 2019-20 was extracted from HCCC 2019-20 Annual Report, Table A5, 157. Data for 2020-21 was extracted from HCCC 2020-21 Annual Report, Table A5, 155. Data for 2021-22 was extracted from HCCC 2021-22 Annual Report, Table A6, 128

Complaints to naturopathy professional bodies

Member associations of the ANC and ARONAH were asked to provide de-identified complaints data for analysis. Data for the years 2016 – 2021 were provided by CMA, NHAA and ARONAH.

Number of complaints

Across the two professional associations (CMA & NHAA) and ARONAH, a total of 50 complaints were reported for this period. Table 3.8 shows the frequency of complaints according to the entity where the complaint was lodged, the state or territory of origin of the complainant and the year in which the complaint was lodged.

The majority (n=34 or 68%) of complaints were recorded by ARONAH, the remaining complaints received (n=16 or 32%) were apportioned equally between CMA and NHAA.

NSW and Victoria each recorded 22% of total complaints, 16% originated from Queensland and 14% originated from Western Australia. The jurisdictional origin of 16% of complaints was unknown.

Table 3.8 Complaints data by year, reporting source, and jurisdiction[24]

YEAR	COUNT	%	PROFESSIONAL BODY	COUNT	%	STATE/TERRITORY	COUNT	%
2016	4	8%	ARONAH	34	68%	NSW	11	22%
2017	7	14%	CMA	8		VIC	10	20%
2018	15	30%	NHAA	8	32%	QLD	8	16%
2019	8	16%				WA	8	16%
2020	8	16%				SA	2	4%
2021	8	16%				ACT	2	4%
						NT	1	2%
						Unknown	8	16%
	50			50			50	

Types of complaints

Table 3.9 sets out the types of complaint received by the naturopathy professional associations and ARONAH. The 50 contacts generated 76 discrete complaints, a rate of 1.5 complaints per complainant. Complaints were classified according to NSW HCCC guidelines (NSW HCCC 2020: 150-152) and grouped into six categories: treatment (31.6%), professional conduct (25%), fees and costs (18.4%), communication (14.5%), records and reports (6.6%), and clinic environment (1.3%). Two complaints were not categorised because insufficient details were provided.

Table 3.9 Complaints categorised by type

Complaint category	Count	%
Treatment	24	31.6%
Professional conduct	19	25.0%
Fees & costs	14	18.4%
Communication	11	14.5%
Records & reports	5	6.6%
Clinic environment	1	1.3%
Unknown	2	2.6%
TOTAL	76	
Complaints per complainant	1.5	

The complaints received were categorised as follows:

- ***Treatment*** – 24 complaints (31.6%) across three sub-categories: treatment, diagnosis, or co-ordination of care that was inappropriate, inadequate, excessive, unexpected, or delayed; dispensing or administration of medication; and access, availability, or refusal to admit or treat.
- ***Professional conduct*** – 19 complaints (25.3%) across five sub-categories: breach of guidelines/law, illegal practice, or scientific fraud; misrepresentation of qualifications; breach of guidelines/law, sexual misconduct, assault, or boundary violation; breach of guidelines/law, advertising; and impairment.
- ***Fees and costs*** – 14 complaints (17.7%) related to cost of treatment, billing practices, and financial consent.
- ***Communication/information*** – 11 complaints (13.9%) across two sub-categories: attitude/manner; incorrect/misleading information provided, or inadequate information.
- ***Records and reports*** – 5 complaints (7.6%) across two sub-categories: refusal to provide records or reports, timeliness of provision, and cost of provision of reports and certificates; medical records – access to/transfer of records.
- ***Clinic environment*** – one complaint (1.3%) related to clinic environment, environmental management, cleanliness/hygiene of facility.

The profile of complaint types reported by the NSW HCCC differs from the profile reported by professional associations and ARONAH. While the numbers are small, it appears that professional bodies received proportionally

24 Complaints made to naturopathy professional bodies may have some duplication as there is no established mechanism for sharing of complaints details between professional bodies.

more complaints about treatment, compared with the NSW HCCC (31.6% of complaints compared with 26.0% of complaints to NSW HCCC), and considerably fewer complaints regarding professional conduct (25.3% of complaints to professional bodies compared with 45.4% to the NSW HCCC). Proportionally more complaints were received by professional bodies about fees and costs (17.7%) compared to the NSW HCCC (7.0%), while complaints lodged with professional bodies regarding communication/information were proportionally fewer (13.9%) compared to NSW HCCC (17.8%). While this finding is consistent with earlier research (Wardle et al., 2014), it is not clear why and may be due in part to differences in classification of complaints.

3.11 DISCUSSION

It is difficult to draw firm conclusions about the complaints profile of naturopaths and herbalists given the data limitations – data was available only from NSW and Victoria and in Victoria complaints about naturopaths and herbalists were not separately reported from 'natural therapists'; there is very little information published by the Victorian HCC about the prohibition orders issued; and it is not clear what proportion of the complaints dealt with by professional associations and ARONAH were also received by HCEs.

Despite these limitations, several points can be made.

First, the reporting of adverse events associated with the practice of naturopathy and WHM needs to be strengthened.

In 2005, Lin & colleagues found:

- numerous adverse reactions to herbal and nutritional medicine in the literature, presenting the results by herb, by nutrient, and by body system, as well as interactions of herbal substances with pharmaceuticals and failure of good handling and manufacturing processes
- the types of events reported by practitioners to be significant, including severe gastrointestinal symptoms, palpitations, and hepatotoxicity
- workforce survey data calculating that practitioners experience one serious adverse event every 11 months of full-time practice, and 2.3 adverse events for every 1,000 consultations (excluding mild gastrointestinal effects) (Lin et al., 2005: 54)
- overall, one third of practitioners reported that they notify adverse events to a variety of agencies, although it is of concern that these reports were largely provided back to the manufacturer or supplier of the product, rather than to the Australian Government Department of Health's Adverse Drug Reactions Advisory Committee (ADRAC)

Since then, the bibliometric analysis shows an exponential increase in research effort and interest directed at documenting the adverse effects of herbal and nutritional medicines. This effort has not been matched by governments, with less reporting of data about naturopaths by complaints bodies and little transparency about the performance of regulators in this area.

Some of the risks can be mitigated by better educated practitioners who are trained to understand the indications, contraindications, and interactions associated with the use of herbal and nutritional medicines.

Successive government reports have called for reforms to the way information on adverse effects of herbal medicines are recorded and published (Bensoussan & Myers 1996; The Expert Committee on Complementary Medicines in the Health System 2003; Lin et al., 2005)

> *...the utility of many adverse reaction reports involving complementary medicines on the TGA's ADRS database appears to be limited because a lack of recorded product information does not allow an unequivocal determination of the identity of the product. Moreover, the ADRS database does not support searching for individual ingredients in multi-ingredient products (such as most herbal and naturopathic medicines* ***(2005: 54).***

The Lin Report made a suite of recommendations to address the risks identified, including that:

- ***education institutions*** provide better training of student naturopaths on how to prevent and deal with adverse events, to initiate appropriate referral practices, to report adverse events, and to recognise the limitations of practice
- ***professional associations*** in conjunction with relevant government agencies promote a centralised location for reporting and recording of adverse events related to nutritional and herbal medicine practice
- ***the TGA ADRS database*** be substantially modified to increase its usefulness for assessing adverse events associated with complementary medicine
- ***national funding bodies*** such as the National Health and Medical Research Council allocate funding for research to quantify adverse events in nutritional and herbal medicine and the interactions with Western pharmaceuticals (Lin et al., 2005: 55-56)

However, no recent ADRAC data was found concerning reporting of adverse effects of naturopathic medicines and nothing to indicate any of the recommendations listed above have been implemented.

Second, the data suggests that the annual rate of complaints against naturopaths and herbalists has increased substantially.

Comparing the dataset presented in the Lin Report with the data collected in this study, the number of complaints per year to HCEs about naturopaths has increased approximately four-fold, faster than the general rate of increase in complaints numbers reported by NSW and Victorian HCEs during the same period. Reasons for this are not known but may be due to increased awareness of consumers about avenues of complaint.

In 2005, Lin & colleagues found:

- 35 complaints about alternative health providers were reported to the NSW HCCC over a five-year period (1998-99 – 2002-03), an average of seven complaints per year
- 88 complaints about alternative therapists in general were made to the Victorian Health Services Commissioner[25] over a seven-year period (1996-97 – 2002-03), an average of 13 complaints per year (Lin et al., 2005: 35)

It is estimated that the annual number of complaints about naturopaths, herbalists, and other natural therapists has increased by 129% over the past 20 years, more than double the number of complaints reported to the HCCC in the most recent five years, compared to the complaints rate reported by Lin & colleagues in 2005. The rate of complaints in Victoria is estimated to have increased by 85% over the past 20 years.

Third, the estimated national figure of 72 complaints per annum is most likely an underestimate given research findings on complaints management systems generally (Lin et al., 2005: 55; Ryan, Too & Bismark 2018; Bismark et al., 2006). The evidence also suggests that the complaints rate would likely be higher if statutory registration were in place, as occurred following the introduction of registration of Chinese medicine practitioners in Victoria. Such increases have been attributed to greater awareness of registration and the role and powers of the regulator (Lin & Gillick 2011: C).

Fourth, the treatment methods used by naturopaths and herbalists, combined with their scope and context of practice suggest a risk profile that is higher than two thirds of the 16 NRAS-registered health professions.

There is concern that the risk profile for naturopathy is increasing due to factors such as:

- the loss of government incentives, for naturopaths and herbalists to participate in voluntary certification (loss of private health insurance rebates or naturopathic treatments; removal of naturopathic education programs from the Health Training Package)
- concurrent use of pharmaceutical medicines along with herbal medicines and nutritional supplements (Morgan et al., 2012)
- the development of manufacturing techniques that alter the potency of products (2005: 55, 292)
- the use of naturopathic and herbal medicines to a wider range of illnesses (2005: 292)
- the accessibility of products from overseas suppliers with unknown manufacturing standards and product authentication processes (2005: 46-7, 292)

Of particular concern, case reports along with complaints data from the NSW and Victorian HCEs over a 20-year period show a small but recurring rate of cases of serious misconduct, a pattern of harm that includes deaths and serious injuries. While the numbers are small, the consequences are catastrophic for the patients involved and their families. This pattern suggests that despite the introduction of further regulatory mechanisms, these risks have not been mitigated.

3.12 CONCLUSIONS

This chapter documents the risks to patients associated with the practice of naturopathy and WHM, and the pattern of harms that is occurring.

Naturopaths and herbalists increasingly practise in the area of 'general medicine' as their reach across the community continues to grow. Naturopathy has been described as the 'general practice' of natural therapies (WHO 2010: 1) in that naturopaths and herbalists deal with a wide range of illnesses and conditions, often of a chronic and serious nature.

The scope of practice of naturopaths includes a comparatively large number of high-risk activities, compared with most of the health professions regulated under the NRAS. Risks arise from the treatment modalities used by naturopaths (prescribing and supply of naturopathic medicines and nutritional supplements), the exercise of clinical judgement by the practitioner, the scope of practice, and the context of practice.

Two sources of risk are of particular concern.

First, there is evidence of a pattern of harm associated with the unrestricted entry to practice by unqualified or under-qualified persons who misrepresent themselves to the public as qualified to practice naturopathy.

The annual number of complaints against naturopaths, herbalists, and other natural therapists has increased substantially over the past 20 years. Issues of professional conduct account for almost half of all complaints, while issues related to treatment and communication/ information account for another 44% of patient complaints.

Deaths and serious injuries have occurred. Professional associations that represent naturopaths have few avenues available to address these risks. While professional associations have taken action to warn the public, and in the most egregious cases some HCEs have issued prohibition orders to remove these people from practice, the cases continue to occur.

25 The Victorian Health Services Commissioner was renamed the Victorian Health Complaints Commissioner in 2016 with commencement of the Health Complaints Act 2016 (Vic).

Second, there has been an exponential rise in the reporting of adverse events associated with the use of herbal medicines and nutritional supplements, with no evidence of progress by regulators in over 20 years to document and publish data on the scale and nature of the problem. Herbal medicines have predictable and unpredictable effects, as well as potentially interacting with pharmaceutical drugs. Adverse events due to acts of commission and omission by naturopaths or herbalists potentially have serious consequences, most recently evident during the COVID-19 pandemic. The risk of harm to patients may be mitigated by proper training of practitioners but there is no mechanism to enforce minimum education standards for entry to practice as a naturopath.

Reporting of adverse events by naturopaths and herbalists needs to be strengthened through appropriate centralisation of data, using the established processes of the Australian reporting procedures for adverse drug reactions. The professions need to work with the Adverse Drug Reactions Unit (ADRU) of the TGA to increase awareness of the reporting mechanisms among their members.

It is imperative that naturopaths and herbalists are properly trained to work as primary care clinicians and are well integrated within the broader primary care and public health systems. Given the scope and context of practice of naturopaths and herbalists that includes use of ingestive therapies as a principal modality, and the range of associated risks, degree level training is considered the minimum level necessary to ensure safe and competent practice.

The degree of risk to public health and safety and the pattern of harms that this report has document warrant the attention of governments and stronger regulation. Options for reform are addressed in Chapter 10.

4
THE BENEFITS OF NATUROPATHY AND WESTERN HERBAL MEDICINE

Stephen P Myers, Anne-Louise Carlton & Jenny Carè

4.1 INTRODUCTION

In assessing the need for stronger regulation of the naturopathy profession, a key objective of this study is to understand not only the risks associated with naturopathic and WHM practice but also the benefits – discussion about the risks of an intervention or therapy should not occur outside an understanding of its attendant benefits (2005: 68).

The purpose of this chapter is to present an overview of the scientific literature on health outcomes associated with naturopathic and WHM clinical practice. Two types of the literature are of interest:

- the scientific literature on the key practices or modalities employed in naturopathic practice, that is, herbal medicine and nutritional supplementation, and
- the scientific literature on whole-of-practice, that is, where naturopathy is evaluated in a clinical practice setting, either through clinical audits or randomised studies of clinical practice with an appropriate control group

Over the past 20 years successive studies have investigated and assessed the scientific literature on the health benefits for patients of naturopathic clinical treatments. These studies include two government reviews (Lin et al., 2005; NHMRC, 2015), two systematic reviews of whole-system naturopathic medicine (Oberg et al., 2015; Myers et al., 2019) and a global health technology assessment of naturopathy (Lloyd, Steel & Wardle 2021).

We know from these previous reviews and studies that a comprehensive review of the scientific literature on the impacts and benefits of naturopathy and naturopathic practice would likely generate tens of thousands of references and require resources that are beyond the capacity of this study. Instead, we present here two pieces of research:

First, a bibliometric analysis of citations in the published literature concerning the 'tools of trade' of naturopaths (herbal medicines and nutritional supplements) undertaken to illustrate the scope and scale of the scientific literature on naturopathy and WHM.

Second, a critical review of five landmark studies documenting evidence about the effectiveness of naturopathy and WHM, to weigh the evidence presented and draw conclusions about the body of knowledge on the benefits of naturopathy and WHM.

4.2 METHODOLOGY

As outlined above, this study was undertaken in two parts: a bibliometric analysis of the published literature and a review of published systematic reviews and grey literature (government reports).

Bibliometric analysis

A search was undertaken to identify the number of citations in MEDLINE (via Ovid) for each year from 1971 to 2021 inclusive. The search was undertaken on 6 October 2022 and 7 October 2022. Textbox 4.1 lists the search terms used.

Textbox 4.1: Search terms used in bibliometric analysis of PubMed citations on herbal medicines and nutritional supplements

For Herbal Medicines

(herbal medicine [MH] OR herbal medicine OR phytotherapy [MH] OR phytotherapy OR plants, medicinal [MH] OR medicinal plants OR supplement*, herbal OR herb) NOT herbicides

For Nutritional Supplements

(((dietary supplements [MH]) NOT (herbal supplement* OR supplement*, herbal)) OR ((dietary supplement* OR supplement*, dietary OR food supplement* OR nutraceutical* OR vitamin* OR (mineral* NOT geology)) NOT herbal medicine [MH])) NOT herbicides

To determine the types of papers published, the search strategy was rerun in PubMed using the filter functions to identify the contribution of clinical trials, and systematic reviews of randomised clinical trials to identify the number of citations published. Also, to further characterise the literature on the naturopathic medicine tools of trade, an analysis was undertaken of the top 15 journals for both herbal medicine and nutritional supplements.

Critical review of government reports and systematic reviews – 2000-2022

To identify studies that included an assessment of the scientific literature on the health benefits associated with naturopathy and WHM clinical practice, a review of the published and grey literature was undertaken and advice on relevant studies was sought from the Research Reference Group members and other technical advisors.

Five studies were identified (Lin et al., 2005; Australian Government Department of Health 2015; Oberg et al., 2015; Myers & Vigar 2019; Lloyd et al., 2021). These were a combination of government reports (n=2), peer reviewed journal articles (n=2) and one health technology assessment. A sixth research study was identified, initiated by the Australian Government Department of Health as a follow up to its 2015 study, but at the time of writing it is yet to publish its final report, hence has not been included.

The five publications are set out in Table 4.1, along with a brief description of the methodologies used.

Table 4.1: Publications assessing the potential benefits associated with naturopathy and WHM

Government reports		
Year	**Publication**	**Description**
2005	Myers S.P., Bensoussan, A., O'Connor, J., Paul-Brent, P., Baker, D., Wohlmuth, H., Cheras, P. A review of the reviews of the benefits of naturopathy and Western herbal medicine. In: Lin, V., Bensoussan, A., Myers, S.P., McCabe, P., Cohen, M., Hill, S., & Howse, G. (2005). *The practice and regulatory requirements of naturopathy and Western herbal medicine*. Victorian Department of Human Services, Melbourne.	• A general citation review • An evaluation of the extent of pharmacological research in herbal medicine • A literature review of herbal medicine and nutritional supplements research
2015	Australian Government Department of Health (2015). Review of the *Australian Government Rebate on Natural Therapies for Private Health Insurance*, Commonwealth of Australia, Canberra (The Natural Therapies Review Report)	• A search for clinical audit literature only
Peer review journal articles		
Year	**Publication**	**Description**
2015	Oberg, E., Bradley, R., Cooley, K., Fritz, H., Goldenberg, J., & Seely, D. (2015). Estimated effects of whole-system naturopathic medicine in select chronic disease conditions: A systematic review. *Alternative & Integrative Medicine*, 4(2), 1–12.	• A systematic review of 15 North American studies on whole practice naturopathic medicine
2019	Myers, S. P., & Vigar, V. (2019). The State of the Evidence for Whole-System, Multi-Modality Naturopathic Medicine: A Systematic Scoping Review. *The Journal of Alternative and Complementary Medicine*, 25(2), 141–168.	• A scoping review of 33 studies providing evidence for whole-system multi-modality naturopathic medicine.
Health technology assessment		
Year	**Publication**	**Description**
2021	Steel, A., Foley, H., D'Souza, J., Adams, J., Wardle, J., Lloyd, I. Chapter 16. Research Dissemination by the Global Naturopathic Research Community. In: Lloyd, I., Steel, A., & Wardle, J. (2021). *Naturopathy: Practice, effectiveness, economics & safety*. World Federation of Naturopathic Medicine, Ontario, Canada.	• Bibliometric analysis of naturopathic peer-reviewed publications • Effectiveness of naturopathic clinical practice • Research on naturopathic therapeutics and practices

4.3 RESULTS OF BIBLIOMETRIC ANALYSIS OF SCIENTIFIC LITERATURE ON THE TOOLS OF TRADE OF NATUROPATHS AND HERBALISTS

The search identified 672,340 citations: 151,425 citations for herbal medicines and 520,915 citations for nutritional supplements. Table 4.2 sets out the number of citations per year. The total number of citations per year for the combination of herbal medicines and nutritional supplements is set out in Figure 4.1.

The total number of citations for herbal medicines per year is given in Figure 4.2 and for nutritional supplements per year in Figure 4.3. There were 6,389 randomised controlled trials and 3,156 systematic reviews published on herbal medicines (Table 4.3); and 38,007 randomised controlled trials and 11,625 systematic reviews published on nutritional supplements between 1971 and 2021 (Table 4.4). Overall, this gives a total of 44,396 randomised controlled trials and 14,781 systematic reviews on the tools of trade for naturopathic medicine. Figure 4.4 shows the number of clinical trials and systematic reviews published per year for herbal medicine, and the number for nutritional supplements is in Figure 4.5.

Between 1971 and 2000 the volume of research on herbal medicine and nutritional supplements increased at a slow but steady rate. From 2000 onwards, scientific interest and research on these products gathered momentum, accelerating even further from around 2010 to the present.

The reasons for such a marked increase in research interest over the past 50 years are not known. We know from an analysis of the bibliometric data that the greatest increase in published research on herbal products came from China followed by the United States. We also know that there has been a marked rise in research relating to the following subjects (in descending order): dietary supplements, plant extracts, cannabis, vitamin D, and Chinese herbal drugs. Apart from cannabis, the products subject to increasing research are the tools of the trade used routinely by naturopaths in clinical practice. The rising research interest in herbal medicine and nutritional supplements shows no signs of diminishing.

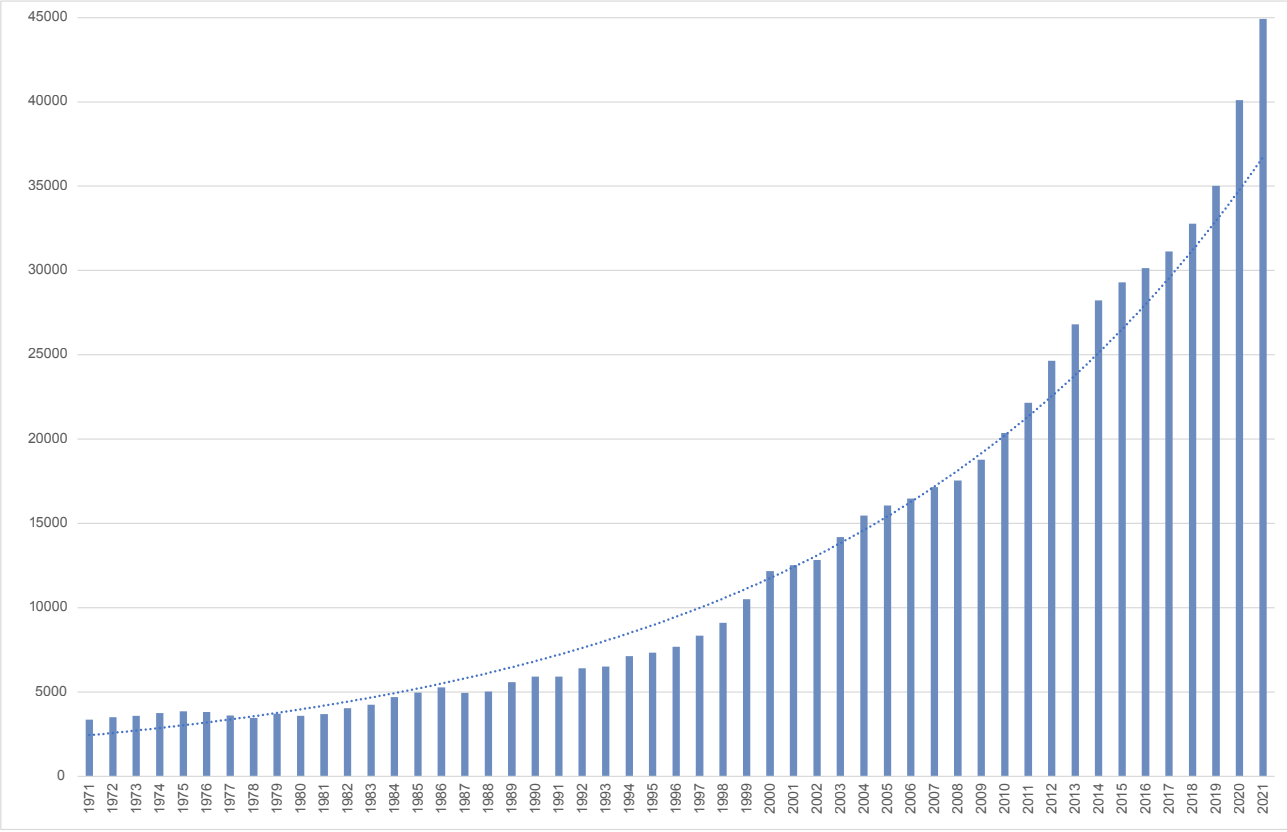

Figure 4.1: MEDLINE citations for herbal medicine and nutritional supplements by year of publication

Table 4.2: MEDLINE citations for herbal medicine and nutritional supplements by year

Year	Herbal Meds	Nut Supp	Total
1971	738	2,624	3,362
1972	788	2,722	3,510
1973	913	2,684	3,597
1974	885	2,867	3,752
1975	726	3,136	3,862
1976	733	3,086	3,819
1977	547	3,073	3,620
1978	547	2,919	3,466
1979	596	3,108	3,704
1980	529	3,054	3,583
1981	587	3,096	3,683
1982	632	3,403	4,035
1983	684	3,574	4,258
1984	781	3,911	4,692
1985	1,003	3,969	4,972
1986	1,072	4,198	5,270
1987	814	4,129	4,943
1988	786	4,235	5,021
1989	754	4,834	5,588
1990	866	5,043	5,909
1991	972	4,950	5,922
1992	1,044	5,359	6,403
1993	1,015	5,499	6,514
1994	1,328	5,798	7,126
1995	1,278	6,048	7,326
1996	1,452	6,225	7,677
1997	1,607	6,729	8,336
1998	1,802	7,310	9,112
1999	2,472	8,044	10,516
2000	3,380	8,786	12,166
2001	3,264	9,254	12,518
2002	3,131	9,703	12,834
2003	3,450	10,750	14,200
2004	3,895	11,564	15,459
2005	4,101	11,962	16,063
2006	4,121	12,356	16,477
2007	4,371	12,778	17,149
2008	3,993	13,548	17,541
2009	4,330	14,440	18,770
2010	4,904	15,462	20,366
2011	5,338	16,813	22,151
2012	5,762	18,884	24,646
2013	5,987	20,828	26,815
2014	6,507	21,720	28,227
2015	6,434	22,861	29,295
2016	7,138	22,999	30,137
2017	7,037	24,095	31,132
2018	7,332	25,451	32,783
2019	8,053	26,960	35,013
2020	9,411	30,687	40,098
2021	11,535	33,387	44,922
TOTAL CITATIONS	**151,425**	**520,915**	**672,340**

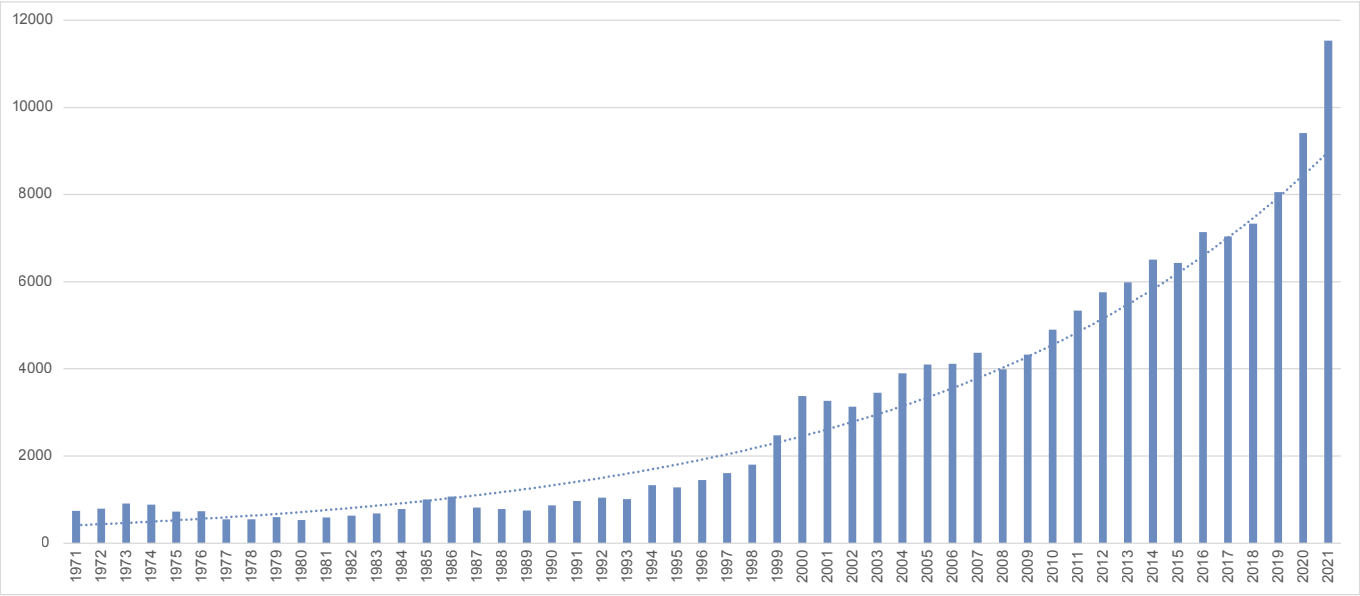

Figure 4.2: MEDLINE citations for herbal medicine by year of publication

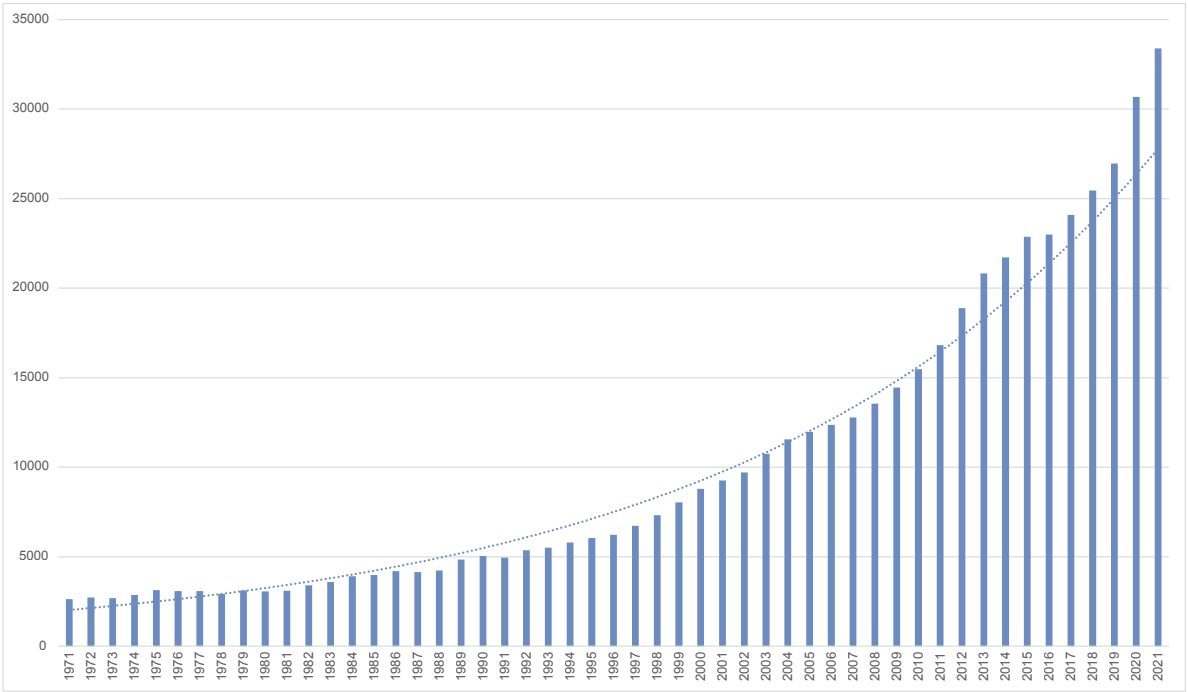

Figure 4.3: MEDLINE citations for nutritional supplements by year of publication

Table 4.3: PubMed citations for herbal medicines by type per year

Year	SR & MA	RCTs	Other	Total
1971	0	3	706	709
1972	0	3	671	674
1973	0	5	752	757
1974	0	7	768	775
1975	0	4	593	597
1976	0	4	573	577
1977	0	2	579	581
1978	0	6	546	552
1979	0	4	648	652
1980	0	5	580	585
1981	0	7	685	692
1982	0	12	713	725
1983	0	8	786	794
1984	0	8	907	915
1985	0	9	1,147	1,156
1986	0	15	1,171	1,186
1987	0	8	959	967
1988	0	6	983	989
1989	0	16	955	971
1990	0	33	1,103	1,136
1991	0	24	1,262	1,286
1992	0	20	1,345	1,365
1993	0	22	1,312	1,334
1994	2	43	1,595	1,640
1995	0	33	1,500	1,533
1996	1	40	1,713	1,754
1997	0	59	1,863	1,922
1998	4	81	2,059	2,144
1999	4	90	2,683	2,777
2000	24	128	3,578	3,730
2001	20	172	3,484	3,676
2002	20	180	3,158	3,358
2003	26	228	3,586	3,840
2004	30	267	4,009	4,306
2005	35	303	4,373	4,711
2006	45	277	4,452	4,774
2007	52	320	4,832	5,204
2008	49	282	4,313	4,644
2009	69	325	4,601	4,995
2010	73	329	5,435	5,837
2011	70	373	6,238	6,681
2012	101	389	6,646	7,136
2013	149	371	6,960	7,480
2014	147	320	7,301	7,768
2015	149	337	7,442	7,928
2016	176	308	8,117	8,601
2017	194	303	8,092	8,589
2018	223	284	8,459	8,966
2019	303	267	9,037	9,607
2020	475	370	10,707	11,552
2021	496	279	11,992	12,767
TOTAL CITATIONS	**3,156**	**6,389**	**154,423**	**163,968**

Legend: SR & MA = systematic reviews and meta-analysis; RCTs = randomised controlled trials

Table 4.4: PubMed citations for nutritional supplements by type per year

Year	SR & MA	RCTs	Other	Total
1971	0	16	4,725	4,741
1972	0	17	4,891	4,908
1973	0	27	4,800	4,827
1974	0	17	4,978	4,995
1975	0	38	5,220	5,258
1976	0	40	4,912	4,952
1977	0	37	5,055	5,092
1978	0	38	4,719	4,757
1979	0	46	4,928	4,974
1980	0	52	5,004	5,056
1981	0	57	4,959	5,016
1982	0	72	5,327	5,399
1983	0	80	5,589	5,669
1984	0	92	6,052	6,144
1985	0	113	6,210	6,323
1986	0	97	6,415	6,512
1987	0	127	6,271	6,398
1988	0	142	6,464	6,606
1989	0	175	7,238	7,413
1990	0	258	7,718	7,976
1991	1	257	7,511	7,769
1992	0	306	7,821	8,127
1993	0	364	8,168	8,532
1994	2	458	8,179	8,639
1995	1	502	8,598	9,101
1996	2	406	8,804	9,212
1997	2	538	9,144	9,684
1998	7	580	9,653	10,240
1999	10	639	10,413	11,062
2000	79	720	11,666	12,465
2001	34	739	11,851	12,624
2002	47	773	12,772	13,592
2003	45	967	14,003	15,015
2004	65	1,117	14,887	16,069
2005	101	1,185	16,378	17,664
2006	111	1,333	17,171	18,615
2007	158	1,434	18,116	19,708
2008	150	1,442	19,452	21,044
2009	194	1,560	20,407	22,161
2010	226	1,767	22,686	24,679
2011	274	2,002	24,876	27,152
2012	351	2,158	27,343	29,852
2013	424	2,378	29,310	32,112
2014	474	2,367	30,416	33,257
2015	558	2,529	31,498	34,585
2016	647	2,400	32,122	35,169
2017	777	2,342	33,627	36,746
2018	894	2,177	34,902	37,973
2019	1,121	2,122	37,543	40,786
2020	1,416	2,167	42,568	46,151
2021	1,696	2,011	44,715	48,422
TOTAL CITATIONS	**11,625**	**38,007**	**670,732**	**720,364**

Legend: SR & MA = systematic reviews and meta-analyses; RCTs = randomised controlled trials

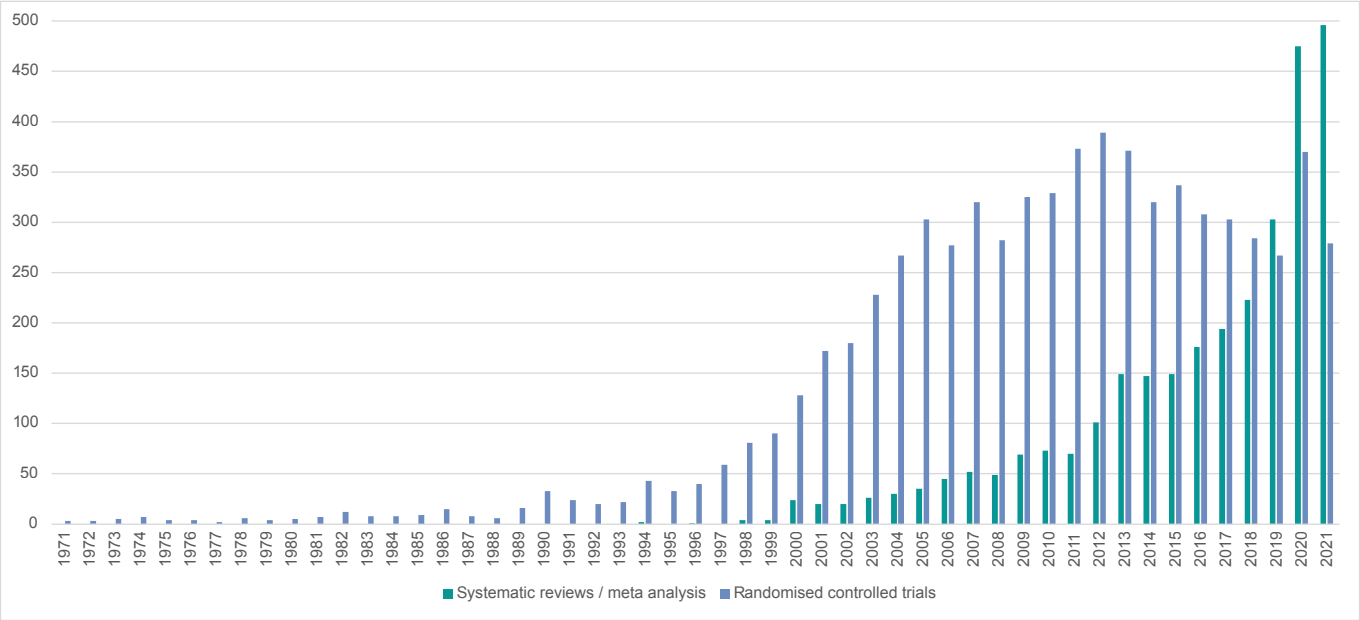

Figure 4.4: PubMed citations for herbal medicine by year of publication, filtered by systematic reviews and meta-analyses, and randomised controlled trials

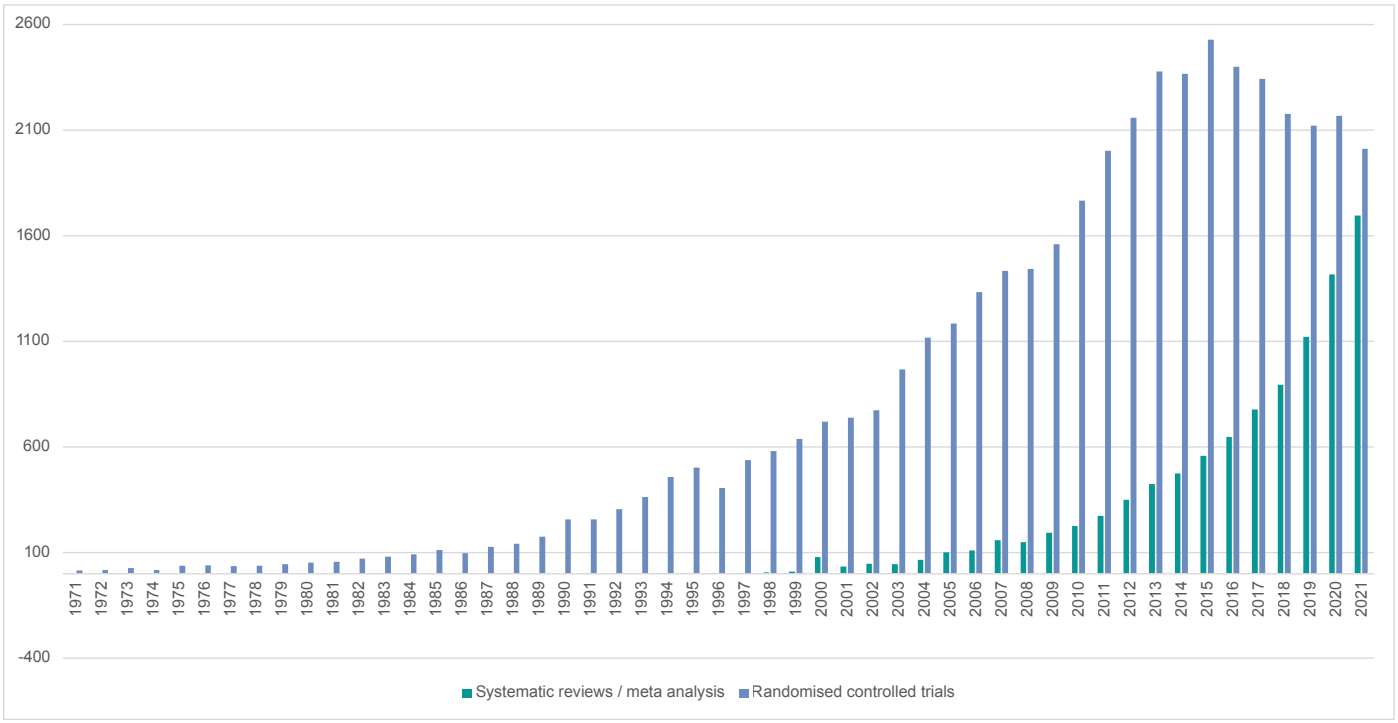

Figure 4.5: PubMed citations for nutritional supplements by year of publication, filtered by systematic reviews and meta-analyses, and randomised controlled trials

The results of analysis of the top 15 journals are presented in Table 4.5 for herbal medicine and Table 4.6 for nutritional supplements. These lists contain many of the Australian Research Council tier 1 journals for the field of complementary and alternative medicine.

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26 See NHMRC Guidelines.

Table 4.5: MEDLINE citations for herbal medicines in top 15 journals

Top Journals	2021 *IF	1971-2021	2011-2021
Journal of Ethnopharmacology	5.195	7,358	4,173
Phytotherapy Research	6.388	5,941	3,206
Phytomedicine	6.656	4,497	2,776
Journal of Chinese Materia Medica	-	4,672	1,962
Molecules	4.927	2,025	1,946
Evidence Based Complementary and Alternative Medicine	2.65	1,942	1,863
BMC Complementary and Alternative Medicine	2.838	1,397	1,270
PLOS One	3.752	1,230	1,199
Frontiers In Pharmacology	5.988	1,024	1,021
Scientific Reports	4.996	844	844
Pharmaceutical Biology	3.889	832	719
Biomedicine Pharmacotherapy	7.49	698	683
Fitoterapia	3.204	1,805	583
Mitochondrial DNA Part B Resources	0.554	562	562
Nutrients	5.797	512	510

Legend: *IF = Impact Factor

Table 4.6: MEDLINE citations for nutritional supplements in top 15 journals

Top Journals	2021 *IF	1971-2021	2011-2021
PLOS One	3.752	7,358	4,173
Nutrients	6.706	5,941	3,206
Scientific Reports	4.996	4,497	2,776
Journal of Bone and Mineral Research	6.39	4,672	1,962
International Journal of Systematic And Evolutionary Microbiology	2.689	2,025	1,946
Science of The Total Environment	10.753	1,942	1,863
Osteoporosis International	5.071	1,397	1,270
International Journal of Molecular Sciences	6.208	1,230	1,199
Bone	4.626	1,024	1,021
Food Chemistry	9.231	844	844
Environmental Science and Pollution Research International	5.19	832	719
Journal of Trace Elements In Medicine and Biology	3.995	698	683
Molecules Basel Switzerland	4.927	1,805	583
Chemosphere	8.943	562	562
Poultry Science	4.017	512	510

4.4 GOVERNMENT REPORTS AND SYSTEMATIC REVIEWS – 2000-2022

Table 4.7 sets out the background and methodology for each of the five research studies.

Table 4.7: Key sources and methodologies used to study benefits of naturopathy and WHM

Background	Methodology
The Lin Report (2005)	
In 2003-05, a consortium of researchers led by Professor Vivian Lin, then Professor of Public Health at La Trobe University was commissioned by the Victorian State Department of Human Services to undertake a study of the risks, benefits, and regulatory requirements for the professions of naturopathy and WHM. The subsequent report published in 2005, included a chapter on the benefits of naturopathy, authored by Myers & colleagues (see Table 4.1) from the following institutions: • Australian Centre for Complementary Medicine Education and Research, a joint venture of the University of Queensland and Southern Cross University • CompleMED, The Centre for Complementary Medicine Research, University of Western Sydney • School of Natural and Complementary Medicine, Southern Cross University	The study was conducted as a 'review of reviews' of the benefits of naturopathy and WHM in three components: • a general citation review • an evaluation of the extent of pharmacological research in herbal medicine • a literature review of herbal medicine and nutritional supplements research For the *general citation review*, a list of the ten most popular and widely used herbal medicines and ten most popular nutritional supplements in Australia in 2004 were selected. Searches were performed using MEDLINE and EMBASE Drugs and Pharmacology up to 2003 – the last complete year. For the evaluation of the *pharmacological research in herbal medicine*, two samples of herbs were selected: the ten most popular herbs that were included in the general citation review and ten randomly selected herbs from the NHAA's course accreditation guidelines (herbs that must be taught as part of an NHAA-accredited course). In addition to searching the major databases, major international pharmacopoeia and WHO monographs were searched to identify monographs on any of the herbs included. The evaluation of literature on nutritional supplements and herbal medicine was limited to systematic reviews published in 2003 that reported on the benefits of nutritional supplements and herbal medicines in humans, and which had used rigorous clinical trial methodology. The papers were reviewed for methodological quality against set criteria.
Australian Government Review of Australian Government Rebate on Natural Therapies for Private Health Insurance (2015)	
The Natural Therapies Review (short title) was undertaken by the Australian Government Department of Health and Chaired by Professor Chris Baggoley, Chief Medical Officer. Its purpose was to assess whether natural therapies for which the Private Health Insurance Rebate was paid are sufficiently underpinned by a credible evidence base that demonstrates they are clinically effective. The Office of the National Health and Medical Research Council (ONHMRC) assisted with the review by engaging third-party contractors to assess the evidence on effectiveness, cost-effectiveness, and safety of the in-scope natural therapies identified. The evidence was assessed in the context of the NHMRC Evidence Guidelines.[26]	Literature searches were restricted to systematic reviews (SRs) published in the English language within the previous five years, provided they were about naturopathic medicine as practised as a health service (clinical audit literature). Systematic reviews of the naturopathic tools of trade were excluded.
Oberg & colleagues' systematic review of whole-system naturopathic medicine in select chronic disease conditions (2015)	
This systematic review was undertaken by North American naturopathic researchers Oberg & colleagues in 2015. It reviewed studies of multi-modality naturopathic medicine (NM) treatment delivered by North American trained naturopathic doctors. The research protocol outlines that the review was of 'whole practice observational treatments or standardized protocols modelling whole practice care (based on naturopathic clinical practices but standardized for research delivery)'; where 'whole practice treatment' was defined as 'the individualized combination of treatments' (Cooley et al., 2012). The authors stated that: *...the research base describing practice outcomes from NM in health and disease is typically assumed to be limited. However, in the domain of patient-centred research, the field of NM has been in the vanguard, defining its priorities in patient-reported outcomes research before well-established nomenclature (and avenues for funding) came into fashion* (Oberg et al., 2015: 2)	This systematic review searched PubMed/MEDLINE, Embase, CINAHL, Cochrane Library, and AMED from inception to April 2012, as well as searches of the grey literature. The search strategy was provided in the PROSPERO registration (preregistered in 2012) and was described as including 'both controlled vocabulary (MeSH) terms, e.g. Naturopathy and Treatment Outcome, and natural language words and phrases, e.g. naturopathic medicine and whole practice' (see PROSPERO [CRD42012002176]). Studies were included if they: 1) were undertaken by a North American (U.S. or Canadian) licensed naturopathic physician (N.D. or N.M.D.) with accredited naturopathic training 2) were intervention trials (classified as RCTs, non-randomised or uncontrolled) or longitudinal observational studies (case-control, cohort, prospective, or retrospective or case series (provided the number was greater than 4 cases), and 3) reported longitudinal outcomes. Studies were excluded if they were: 1) single or monotherapies (with the exception of studies which specify their use in naturopathic clinical practice) 2) preclinical studies (including animal studies) 3) pharmacokinetic or pharmacodynamic trials 4) cross-sectional studies 5) studies undertaken in jurisdictions other than North America 6) studies performed by non-licensed or non-accredited North American naturopathic physicians.

Background	Methodology
Myers & Vigar scoping review of whole-system multi-modality naturopathic medicine (2019)	
This study was undertaken in 2019 by Myers and Vigar from the National Centre for Naturopathic Medicine at Southern Cross University. The researchers noted that while a substantial body of evidence for the effectiveness of the 'tools of trade' of naturopathic medicine (herbal and nutritional supplements and lifestyle interventions) is now available, there exists little quantitative scientific evidence documenting naturopathy as an effective medical practice (Myers & Vigar 2019: 141-142). The objective of the study was to summarise the current state of the research evidence for whole-system, multi-modality naturopathic medicine. The researchers noted that a systematic scoping review differs from a systematic review in that it sets out to examine the extent, range, and nature of research activity in a broad area rather than to answer a focused question by synthesising all available research. Hence, a scoping review does not generally include a comprehensive systematic quality assessment.	A systematic search was undertaken for research articles globally, using MEDLINE, Embase, CINAHL, AMED and WHO regional indexes. Naturopathic journals and grey literature were hand searched and no language restrictions were imposed (Myers & Vigar 2019: 141). Included were: • human research evaluating the effectiveness of naturopathic medicine, where two or more naturopathic modalities were delivered by naturopathic clinicians, and • case studies with five or more cases Hand searches were also conducted of a list of naturopathy-specific journals, and submissions to the Australian Government Review (see **section 4.4.2**) were also searched for references. Risk of bias assessment was conducted on all clinical trial reports using the Cochrane Collaboration Risk of Bias tool (version 1.0). A total of 2,551 titles were located from United States, Canada, Germany, India, Australia, United Kingdom and Japan. Titles and abstracts were screened, with 95 full text primary studies and 12 grey literature studies reviewed. Studies were excluded if they used only a single modality or did not identify that treatments were conducted by naturopathic clinicians.
World Naturopathic Federation Health Technology Assessment (2021)	
This study was undertaken over five years by Lloyd, Steel & Wardle and published by the WNF in 2021. The purpose of the study was to provide the first comprehensive overview of the available scientific literature on the practice, effectiveness, utility, economics, and safety of naturopathy/naturopathic medicine. The HTA report was developed to provide an evidence-based summary of naturopathic practices and outcomes of naturopathic care, with the scope of the HTA informed by research conducted by the international naturopathic community (Lloyd et al., 2021: viii). A large portion of the study was devoted to documenting original clinical research on the effectiveness of naturopathic clinical practice and the research in naturopathic therapeutics and practices.	A protocol for the conduct of the HTA was prepared and published in accordance with the World Health Organization's HTA guidelines, adapted to meet the specific requirements and nature of the naturopathic profession (Lloyd et al., 2021: viii) A bibliometric analysis was undertaken of naturopath-authored peer-reviewed publications and published in The Journal of Alternative and Complementary Medicine (Steel et al., 2021). A snowballing method was employed to identify research articles written by at least one naturopath/naturopathic doctor. Articles were included if at least one author held a naturopathic qualification recognised by the country where they were located, and the article was published in a peer-reviewed, indexed journal (criteria applied). The researchers who were identified through referral were contacted and asked to provide a list of their publications along with other naturopathic practitioners who were also engaged in research. This process was repeated until no new referrals were received. Publications were also searched for in PubMed, Google Scholar and ResearchGate. Each publication list was examined for further articles meeting the eligibility criteria. Articles were imported into an EndNote library where duplicates were removed. The author lists were contacted using the same snowballing method. The results were summarised by 50 authors from 10 countries across six WHO regions. The topic areas were selected based on the number of articles available and the frequency with which the treatment(s) was used, or the condition was reported as treated by naturopathic practitioners. A staged peer-review process was employed for each topic. Analysis of observational studies was also undertaken to summarise survey research, qualitative studies, and other non-clinical research conducted by naturopathic researchers.

4.5 FINDINGS OF THE LIN REPORT – 2005

This study found:

- A substantial body of scientific literature on nutritional substances and herbal medicines, ranging from basic laboratory and animal research to randomised controlled trials (RCTs).
- The citation search for the top ten nutritional medicines and top ten herbal medicines on the Australian market yielded 153,005 citations from 1966 to 2003, incorporating 136,014 citations on the top 10 nutritional supplements and 16,991 citations on the top ten herbal supplements.
- The review of the pharmacological literature on specific herbal medicines found a substantial body of literature covering both popular and randomly selected herbal medicines that covered in vitro studies, animal models, and clinical research.
- A time limited review of systematic reviews assessed the results of more than 1,338 RCTs involving 375,462 subjects, demonstrating evidence that herbal medicines and nutritional supplements provide benefits for a broad range of diseases.

The researchers concluded:

- A range of nutritional supplements and herbal medicines were found to have demonstrable benefits at the highest level of evidence – systematic reviews of RCTs, with these benefits spread across a range of conditions and body systems.
- Some 'tools of trade' of naturopaths and herbalists

have proven efficacy with the safety profiles found to be good, with minor adverse events reported.

The study also pointed to several challenges with evaluating the research literature on naturopathic practice:

- In clinical practice, naturopaths and herbalists use multiple therapeutic tools accompanied by dietary and lifestyle assessment and advice, patient education, and counselling. The disciplines of naturopathy and WHM have not been subject to systematic investigation on the manner in which the disciplines are practised in the community (whole practice or whole-systems research).
- Researching a single herb or nutrient does not reflect whole of practice. In the absence of whole practice research data, the only way to evaluate these disciplines effectively and objectively is to focus on their major therapeutic tools. However, the limitation of this approach is that the effectiveness of a specific therapeutic tool (such as a nutrient or an herbal medicine) is an inadequate indication of the complex clinical interactions that occur in a whole practice setting.
- Many complementary medicine interventions and therapies have yet to be assessed in rigorous clinical trials, and very few of these interventions and therapies have been the subject of systematic investigations of safety.

4.6 FINDINGS OF THE REVIEW OF THE AUSTRALIAN GOVERNMENT REBATE ON NATURAL THERAPIES FOR PRIVATE HEALTH INSURANCE – 2015

The *Overview of herbal medicine* published as part of this Australian Government Review report identified no systematic reviews of the effects of herbalism as a health service and concluded there was no evidence of clinical effectiveness of any herbal medicine.

With respect to naturopathy, the *Overview of herbal medicine* found only one systematic review conducted on naturopathy practice in the United States (Oberg & colleagues 2015). However, the results of this review were considered inapplicable, the stated rationale being the differences in training and accreditation standards between the US and Australia. Again, the Natural Therapies Review Report concluded there was no evidence of clinical effectiveness of naturopathic practice.

The Australian Government Department of Health accepted the findings of this review and in 2018 withdrew private health insurance rebates for naturopathy and herbal medicine services.

4.7 FINDINGS OF OBERG & COLLEAGUES' SYSTEMATIC REVIEW OF WHOLE-SYSTEM NATUROPATHIC MEDICINE IN SELECT CHRONIC DISEASE CONDITIONS – 2015

In Oberg & colleagues' systematic review of whole-system naturopathic medicine, fifteen studies met the inclusion criteria including randomised controlled trials (RCTs) (n=6), prospective observational cohort studies (n=2), retrospective studies (n=5), and cost-effectiveness analyses (n=2). All the studies were of chronic conditions with six studies evaluating diabetes or cardiovascular disease, five studies in musculoskeletal or pain conditions, and four studies on miscellaneous conditions (multiple sclerosis, temporomandibular disorder, menopausal symptoms, and hepatitis C).

The six RCTs were assessed as having a low-risk of bias in most domains with the exception of blinding which the review points out is a 'recognized impracticality in whole-system research' (Oberg et al., 2015: 4). Due to this limitation, the assessed risk of bias was graded as high for all but one of the RCTs.

The review noted that in the primary outcome studies:

> ***Rates of health promotion delivery were substantially higher than national primary care averages; evidence-based therapeutic lifestyle change recommendations (dietary) were made for 100% of patients and 94% of patients were prescribed exercise; 69% of patients received counselling regarding stress reduction techniques. (Oberg et al., 2015: 5)***

These studies found primary outcomes that demonstrated a positive effect from naturopathic medicine including:

- a 16.9% decrease in the prevalence of metabolic syndrome compared to usual care
- improved glycaemic control (measured as reduced HbA1c)
- improved blood pressure (reductions up to 26mmHg systolic and 11mmHg diastolic)
- decreased anxiety (greater than 50% reduction in comparison to active psychotherapy controls), decreased pain with greater than 50% reduction in chronic low back pain and in rotator cuff tendonitis in comparison to active physiotherapy controls; a reduction in the pain of temporomandibular syndrome, and
- the reduction in neck and back pain alongside an improvement in quality of life

Effect sizes (calculated as Cohen's D) showed that 10 out of 13 studies had statistically significant ($p<0.05$) improved outcomes.

The researchers concluded that naturopathic medicine appears to be a system of medicine with potentially positive public health implications for a wide variety of chronic health conditions (Oberg et al., 2015: 9).

4.8 FINDINGS OF MYERS & VIGAR'S SCOPING REVIEW OF WHOLE-SYSTEM MULTI-MODALITY NATUROPATHIC MEDICINE – 2019

In Myers & Vigar's scoping review of whole-system multi-modality naturopathic medicine, 33 published studies met the inclusion criteria across a range of mainly chronic clinical conditions, totalling 9,859 study participants. Included studies were categorised by clinical condition, study design, clinical setting (outpatient or inpatient) and modalities used.

The researchers found that predominantly studies showed evidence for efficacy of naturopathic medicine. They found that research in whole-system, multi-modality naturopathic medicine showed it is effective for treating cardiovascular disease, musculoskeletal pain, type 2 diabetes, polycystic ovary syndrome, depression, anxiety, and a range of complex chronic conditions (see Textbox 4.2).

The researchers found that results were positive across world regions for similar conditions, suggesting global consistency in applying the core concepts of naturopathic practice utilising the common set of naturopathic modalities.

The researchers noted a debate within the profession between those who see evidence-based medicine as antithetical to naturopathy and others who acknowledge that although tensions exist between T&CM and EBM epistemologies, these tensions and their resolutions also can hold the key to a more productive understanding between traditional and scientific knowledge (Myers & Vigar 2019: 142).

The researchers concluded that:

> *...although there is a vast array of clinical trial evidence supporting the tools of trade used in naturopathic medicine (dietary and lifestyle interventions and specific botanical medicines and nutritional supplements), there is a distinct lack of well-conducted pragmatic trials evaluating the complex intervention of whole-system, multi-modality naturopathic care. Until substantively more whole-system research is undertaken, evaluating the effectiveness of naturopathic medicine requires a combination of both these types of evidence (Myers & Vigar 2019: 166)*

Textbox 4.2: Myers & Vigar findings on evidence of efficacy of naturopathic medicine

Cardiovascular disease – these studies showed naturopathic treatment resulted in a clinically significant benefit for the treatment of hypertension, reduction in metabolic syndrome parameters, and improved cardiac outcomes post-surgery.

Type 2 diabetes – these studies showed naturopathic treatment resulted in a significant benefit for the treatment of diabetes, with clinically relevant reductions in HbA1c.

Musculoskeletal pain – these studies showed that naturopathic treatment decreased pain scores to a degree comparable with or better than standard care or other active treatment controls.

Mood disorders – these studies showed significant reductions in reported levels of anxiety and depression.

Complex chronic disease – these studies showed an overall positive effect on quality of life (QOL) and symptomatic improvement.

Asthma – these studies showed significant positive results in lung function parameters from intensive inpatient naturopathic treatment of asthma.

4.9 FINDINGS OF THE WORLD NATUROPATHIC FEDERATION'S HEALTH TECHNOLOGY ASSESSMENT – 2021

The findings from the WNF Health Technology Assessment (2021) are presented in three sections: the bibliometric analysis, the evidence of effectiveness of naturopathic clinical practice and clinical treatment outcomes associated with naturopathic modalities and practice.

Bibliometric analysis

The first section presents the results of the bibliometric analysis, which identified 2,218 manuscripts, published by naturopathic researchers from 22 countries and indexed in peer-reviewed journals. The publication period spanned 1987-2019 with more than 80% of the articles published since 2008, 27.8% of which were conducted by Australian naturopathic researchers.

Results from these studies showed a positive response to at least one primary or secondary outcome measure in more than 80% of effectiveness studies of naturopathic clinical practice treatment in over 80 different illness populations.

Evidence of effectiveness of naturopathic clinical practice

The second section presents the evidence of effectiveness of naturopathic clinical practice. Of 235 original clinical research articles, over 60% were randomised controlled trials. Also included were uncontrolled trials, case reports, cohort studies, secondary analyses, and non-randomised controlled studies.

The naturopathic individualised patient-centred approach to healthcare that uses a range of treatments and practices was found to be well-suited to the prevention, treatment, and management of a diverse range of conditions including:

- cancer
- cardiovascular conditions
- complex immune conditions
- endocrine conditions
- gastrointestinal conditions
- mental health condition
- musculoskeletal conditions
- neurological conditions
- women's health
- skin conditions

These studies also show that non-communicable diseases, which are strongly associated with modifiable risk factors such as lifestyle behaviours, physical inactivity, sedentariness, obesity, alcohol consumption, dietary choices and environmental exposures, are routinely addressed as part of naturopathic preventative care.

The researchers found that internationally, naturopaths have been instrumental in the development of integrative oncology and nutritional psychiatry and have been at the forefront of recognising the importance of gastrointestinal health to overall health.

Clinical treatment outcomes associated with naturopathic modalities and practice

The third section presents clinical treatment outcomes associated with naturopathic modalities and practice. Of 304 original clinical research articles covering more than 140 conditions, over half the studies were randomised controlled trials (n=165). Also included were case reports, uncontrolled trials, secondary analyses, cohort studies, comparative controlled trials, pilot studies, non-randomised controlled studies, observational studies, and exploratory analyses.

The section details commonly employed pragmatic elements of clinical naturopathic practice such as multi-modal interventions and flexibility in administration in real-world settings. The researchers reported a positive response to at least one primary or secondary outcome measure using naturopathic treatment options including:

- complex naturopathic interventions
- applied nutrition
- clinical nutrition
- herbal medicine
- lifestyle and exercise
- bodywork
- mind-body medicine and counselling

The WNF HTA notes:

- the naturopathic research community has produced peer-reviewed literature for over 30 years, demonstrating a sustained commitment to codifying and synthesising existing knowledge, generating new knowledge and disseminating this to the wider clinical and research community
- the volume of peer-reviewed literature authored by naturopaths has grown exponentially over the last 20 years
- the diversity of topics reflects the varied treatments used, conditions managed, and populations supported by naturopathic care globally
- most of the research output is produced by naturopathic researchers affiliated with institutions of higher education and university-based research facilities
- there is substantial and growing evidence of the effectiveness and benefits of naturopathic treatment approaches in patients throughout all life stages, for preventative care, in acute, chronic and complex conditions, and for end-of-life care (Lloyd et al., 2021: 138)

4.10 DISCUSSION

Benefits of naturopathy and WHM

There is a substantial body of scientific literature to support the conclusion that naturopathy is an effective system of health care. This literature encompasses both the tools of trade of naturopathy (herbal medicines and nutritional supplements) and naturopathy as a whole system of medicine.

Successive studies outlined here have documented the scope and scale of this literature. This ranges from basic laboratory and animal research to randomised controlled trials and includes whole-of-practice research that has evaluated the effectiveness of naturopathy and WHM as primary care practices.

Any assessment of the scientific literature on naturopathy and WHM needs to consider literature that demonstrates both the biological plausibility and direct evidence on the

primary tools of trade (herbal medicines and nutritional supplements). The bibliometric analysis of the scientific literature provides support for naturopathic medicine's primary tools of trade (herbal medicines and nutritional supplements) and demonstrates there is an immense body of literature that is far beyond the scope of any independent review to summarise directly.

A consistent finding, supported by the results of the bibliometric analysis reported here, is that the scale and scope of the literature is beyond the resources of researchers to review in its totality. As a result, successive researchers have found it necessary to adopt various sampling techniques where only a sub-set of the literature is assessed.

The research undertaken in the Lin Report (2005), the systematic review (Oberg et al., 2015), the scoping review (Myers et al., 2019) and the WNF Naturopathic Medicine Health Technology Assessment (Lloyd et al., 2021), all conclude that there is a substantial body of evidence that demonstrates the effectiveness of naturopathic medicine and WHM as health practices:

- The Lin Report presented a three year (2001-2003) limited review of systematic reviews on the effects of nutritional supplements (n=38) and herbal medicines (n=34) which assessed the results of more than 1,338 RCTs involving 375,462 subjects and demonstrated the benefits of naturopathic medicine and WHM for major body systems and a wide range of major illnesses.
- Oberg & colleagues' systematic review of 13 studies of the practice of naturopathic medicine in North America found that evidence-based therapeutic lifestyle change recommendations were made for 100% of 1,559 patients seen in these studies; and found positive effects for naturopathic medicine in 10 out of 13 studies, including benefits in metabolic syndrome, high blood pressure, anxiety, chronic low back pain, rotator cuff tendonitis, temporomandibular syndrome, and bodily pain.
- Myers & Vigar's 2019 scoping review of whole-system multi-modality naturopathic medicine found 33 studies comprising 9,859 participants, with naturopathic medicine found to be effective for treating cardiovascular disease, musculoskeletal pain, type 2 diabetes, polycystic ovary syndrome, depression, anxiety, and a range of complex chronic conditions.
- Lloyd & colleagues' 2021 WNF Health Technology Assessment found over 300 original clinical studies by naturopathic researchers that focus on clinical outcomes associated with naturopathic treatment modalities and practices. Studies investigated treatments for over 140 conditions. These clinical studies commonly feature pragmatic elements such as multi-modal interventions, flexibility in administration, and real-world settings. Overall, 77.6% of these studies identified a positive response to at least one primary or secondary outcome measure. Positive outcomes were found in cancer, cardiovascular conditions, complex immune conditions, endocrine conditions, gastrointestinal conditions, mental health conditions, musculoskeletal conditions, neurological conditions, women's health, and skin conditions.

Methodological limitations of the 2015 Natural Therapies Review

The findings of the Australian Government's 2015 Natural Therapies Review are out of step with the findings of the four other studies outlined above, in that the review found no evidence of benefits associated with naturopathic practice. However, the methodology and findings of this review have been strongly criticised on several grounds.

First, the vast majority of the literature on both Western biomedicine and naturopathic medicine relates to their respective tools of trade. For Western biomedicine this literature includes studies on pharmaceutical drugs and surgical procedures whereas for naturopathy and WHM, it includes studies on herbal medicines, nutritional supplements, and lifestyle interventions. The second component is the evidence that evaluates a therapy in the clinical practice setting, using either clinical audit or randomised studies of a clinical practice with an appropriate control group.

A critical assessment of the scientific literature on the benefits of a therapy would be expected to assess two components of the scientific literature – the evidence on the tools of trade and the evidence on whole-of-practice. The methodology adopted by the Natural Therapies Review was flawed in that it failed to take account of the extensive literature on naturopathic tools of trade.

At the time the methodology was being developed for the Natural Therapies Review in 2014, there were 94,485 citations for herbal medicines and 428,960 citations for nutritional supplements listed in MEDLINE (see **Table 4.1**). These citations were excluded from consideration.

By 2023, 720,364 papers were found in the scientific literature on herbal medicines and nutritional supplements comprising 38,007 clinical trials summarised in 11,625 systematic reviews and 670,732 other papers that include extensive preclinical investigations.

A recurring theme in these studies on the benefits of naturopathic medicine tools-of-trade is that the scale and scope of the literature is beyond the resources available to review it in totality; and as a result, a sub-set or sampling processes has been required by groups investigating this field. However, basing important policy decisions (such as the decision to remove private health insurance rebates for naturopathic services) on an assessment of only a sub-set of a profession's scientific literature is problematic.

Second, there are limitations with relying solely on evidence of audit and feedback of clinical practice to assess the benefits of a therapy.

In contrast to the study of pharmacological effects of medicines, clinical audit is a relatively recent development, for instance it was incorporated into clinical governance systems in the UK in 1997 (NICE 2002: 1). The audit process was described by Russell and Wilson as a third clinical science when undertaken using a proven standard and methodological rigour (Russell & Wilson 1992). These studies are often undertaken as part of a quality review process within healthcare organisations and are seldom published.

To illustrate, a 2012 Cochrane Review searched the literature for randomised trials of audit and feedback from 1975 to 2011 and included only 70 studies where audit and feedback were a core component (Ivers et al., 2012). By way of comparison there are over 300,000 papers cited in PubMed for "drug or pharmaceutical" filtered by clinical trial for the same date range 1975 to 2011.

Until the clinical audit literature in both Western biomedicine and naturopathic medicine expands substantially, evaluating a therapy based only on clinical audit literature will produce a biased result that does not reflect the totality of the science available to support either of these health professions. If the clinical audit literature is currently poor, then systematic reviews of the clinical audit literature are comparatively rare. Therefore, restricting a review to systematic reviews of the clinical audit literature in a five-year window, as occurred in the Natural Therapies Review, set the bar so high, it virtually guaranteed that little or no evidence would be found.

Third, the systematic review by Oberg & colleagues that was excluded from consideration was an important study that, arguably, should have been included and considered. Oberg & colleagues found 13 studies that demonstrated naturopathic medicine practised as a health service was effective in treating a range of chronic health conditions.[27]

Oberg and colleagues reported on a decade of work by the North American naturopathic medicine research community arising from the findings of the US National Institutes of Health-funded project to develop a Naturopathic Medicine Research Agenda (Standish et al., 2006). The Research Agenda included a priority for research within naturopathic medicine to undertake whole practice research to determine the effectiveness of naturopathic medicine as a primary care practice.

Naturopathy and WHM stakeholders have argued that the time limited review of systematic reviews of primary clinical audit literature and the subsequent policy decision to remove private health fund rebates for naturopathy services on the basis of a review of clinical audit literature only, at the same time excluding the evidence of effectiveness of the naturopathy tools of trade was neither fair nor reasonable.

2019-20 Review of Australian Government Rebate on Private Health Insurance for Natural Therapies

Due to shortcomings with the first Natural Therapies Review of 2015 (Wardle 2016),[28] the Australian Government initiated a second review, again to be undertaken by the NHMRC.

The Australian Government Department of Health website states that as part of the 'Review of the Australian Government Rebate on Private Health Insurance for Natural Therapies 2019-20' (Natural Therapies Review 2019-20) the Deputy Chief Medical Officer, Professor Michael Kidd, has been asked to provide a final report to the Australian Government. The report will provide recommendations on whether to re-include any of the 16 excluded natural therapies as eligible for benefits under complying private health insurance products.

For the purposes of the Natural Therapies Review 2019-20 'excluded natural therapies' include WHM and naturopathy along with Alexander technique, aromatherapy, bowen therapy, buteyko, feldenkrais, homeopathy, iridology, kinesiology, pilates, reflexology, rolfing, shiatsu, tai chi, and yoga.

The Australian Government has established a Natural Therapies Review Expert Advisory Panel to support the Natural Therapies Review 2019-20 by providing advice to the Deputy Chief Medical Officer Professor Michael Kidd, on:

- any additional evidence of their clinical effectiveness published since the 2014–15 review or high-quality evidence not included in the 2014–15 review to be assessed by the National Health and Medical Research Council (NHMRC)
- the reports on the evidence evaluations to be provided by the NHMRC[29]

The website states that the Natural Therapies Review 2019-20 was initiated because additional evidence on the clinical effectiveness of excluded therapies has been identified since the first review. The NHMRC is supporting the review and has established a Natural Therapies Working Committee to oversee the evidence evaluations for the review.

A detailed methodology for the review has been posted on the Australian Government Department of Health and Aged Care website and includes the establishment of two committees and two substantive processes for each therapy under review, development of a research protocol and development of evidence evaluation.[30]

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27 While at the time of the first Natural Therapies Review, Oberg & colleagues' systematic review was yet to be published, however, preliminary data was available as a conference citation in 2012 (Calabrese et al., 2012) and the systematic review methodology had been preregistered in PROSPERO. The paper was subsequently published in Alternative & Integrative Medicine in 2015.
28 See Natural Therapies Review.
29 See Natural Therapies Review How We're Reviewing It.
30 See Natural Therapies Review Process and Government.

The scope of this second review also has been expanded to include an invitation to natural therapies organisations and members of the public to submit scientific evidence of the clinical effectiveness of the natural therapies under review.[31]

The report on the evidence evaluation of naturopathy is yet to be published. However, the submitted evidence on WHM and naturopathy is available on the Department of Health's website. This document presents over 670 studies on WHM and over 440 studies on naturopathy. While this evidence is still being evaluated by the NHMRC, for the purposes of the current research it provides a substantial body of literature on the effects of naturopathy/WHM and their key modalities.

While naturopathy/WHM stakeholders hoped that the new review would report relatively quickly, the scope of the work involved has caused considerable delays. In the meantime, the original policy decision remains in place, substantially disadvantaging the naturopathy/WHM professions.

Limitations of this study

The database search for the bibliometric analysis was limited to a single database (MEDLINE) for the counts of published articles and hence is likely to underestimate the count of research. Restricting the search to one database also excluded foreign language-specific databases such as for Chinese, Russian, and Spanish language publications and hence did not pick up research from these and other non-Anglophone countries. Although the search terms used for the bibliometric analysis comprehensively covered herbal medicine and supplement terms, it excluded common naturopathic treatments such as lifestyle and dietary advice.

4.11 CONCLUSIONS

Assessments aimed at determining the scientific effectiveness of a therapy need to be conducted in a methodologically robust, fair and unbiased way, considering both the evidence of effectiveness as a clinical practice (the clinical audit literature) and the literature of the effectiveness of the tools of trade.

For reasons set out in this chapter, the methodology adopted by the 2015 Natural Therapies Review was flawed and therefore its conclusions were not well-founded. While the Federal Department of Health has accepted that there were limitations in the first Natural Therapies Review of 2015 and has commissioned a second review, the withdrawal of Private Health Insurance Rebates for patients who use the services of naturopaths and herbalists has remained in place. The effect has been to penalise naturopaths and herbalists and their patients by preventing many Australians from accessing these therapies using their private health insurance.

The research undertaken in the Lin Report (2005), the systematic review (Oberg et al., 2015), the scoping review (Myers et al., 2019) and the WNF Naturopathic Medicine Health Technology Assessment (Lloyd et al., 2021), all conclude that there is a substantial body of evidence that demonstrates the effectiveness of naturopathic medicine and WHM as health practices. This literature encompasses both the tools of trade of naturopathy (herbal medicines and nutritional supplements) and naturopathy as a system of medicine.

Taken together, the studies described in this chapter provide a substantial body of scientific literature on which it is reasonable to conclude that naturopathy and WHM are effective systems of health care, with demonstrated benefits for a wide range of conditions and across all major body systems.

31 See Natural Therapies Review 2019/20.

5
THE NATUROPATHY AND WESTERN HERBAL MEDICINE WORKFORCE

Amie Steel & Sophia Gerontakos

5.1 INTRODUCTION

A competent and well-trained health workforce is essential to ensure the community has access to safe and effective healthcare (Productivity Commission 2005). Naturopathy and WHM constitute traditional medicine systems that are widely practiced in Australia. They are defined by the application of a long-established set of guiding principles and philosophies (World Naturopathic Roots Committee 2017) and specific tools of trade that include herbal medicine and lifestyle advice (Steel et al., 2020c). Understanding the size and characteristics of the naturopathic and WHM workforce helps to understand the role of naturopaths and herbalists in the delivery of healthcare, the extent of consumer access to naturopathic services, the safety profile of the profession, and how best to protect the public from risks associated with its practice.

In 2005, the Lin Report presented the results of a 2003 survey of the naturopathy and WHM workforce in Australia. A summary of the results of this study is set out in Textbox 5.1. The study found that in 2003, the naturopathy and WHM workforce was estimated to be over 2,600 and was providing an estimated 1.9 million consultations annually, at an estimated cost of approximately $85 million in consultation fees (excluding the costs of herbal products, nutritional supplements etc prescribed during the consultation and dispensed directly to the patient) (2005: 99, 103, 107).

Since the Lin Report was published, further studies have reported on the characteristics of the naturopathy and WHM workforce.

The purpose of this chapter is to present the results of a systematic review of the empirical evidence published since 2005 concerning the characteristics of the naturopathy and WHM workforce in Australia, including the demographic features of the workforce, the nature of naturopathic and WHM practice, the profile of patients who use the services of naturopaths and herbalists, and the professional and interprofessional issues reported by naturopaths and herbalists.

Textbox 5.1 Summary of findings from the workforce survey reported in the Lin Report 2005

The practices of herbal medicine and naturopathy make a substantial contribution to the Australian healthcare sector, with approximately 1.9 million consultations annually and an estimated turnover of $85 million in consultation fees (excluding the costs of medicines). In 2005:

- The workforce was predominantly female (76.1%) and the average age of practitioners was 44.1 years.
- Most practitioners reported they used more than one title to describe their practice, with significant overlap between naturopathy and herbal medicine. The most common titles used were 'naturopath' and 'herbalist'.
- There was significant variation in the intensity of clinical practice, with a mean of 24 hours per week (representing 22 consultations per week). Extrapolated across the whole naturopathic workforce, this represented 1.9 million consultations in 2003.
- A significant proportion (38%) of naturopaths used medical tests at least 50% of the time to guide clinical practice. More than 80% of practitioners guided their interventions by using diagnostic approaches specific to naturopathic practice.
- Most practitioners (75%) received patients through word of mouth, and almost half acknowledged occasional referrals from medical practitioners. Only 7% of practitioners worked in multi-disciplinary environments that included medical practitioners.
- The average (mean) clinical experience of practitioners was nine years.
- The cost of treatment was modest with average fees for an initial consultation being AUD$61.70, and for follow-up consultations AUD$42.10.
- Average practitioner income was between $20,000 and $60,000. Total turnover in consultation fees in Australia was estimated at more than $85 million in 2003.
- One third of practitioners usually reported adverse events, but not to ADRAC.
- The reported duration of education ranged from six months to six years. Most practitioners had at least three years of education in herbal or naturopathic practice and an additional 11% held other health qualifications. However, almost half felt that they were inadequately prepared for inter-professional communication, and almost a quarter that their clinical training was inadequate. Participation in continuing education was high (88%).
- Half of the workforce belonged to two or more professional associations. There was a very large number of small associations (115).
- A majority of practitioners viewed government regulation as having more positive implications than negative implications, and most supported more practitioner regulation.
- A majority of practitioners were registered with health insurance funds as providers. Most held professional indemnity insurance, but a small number had no such insurance.

Source: Lin et al., 2005: 97-117

5.2 METHODOLOGY

This systematic review examined literature on the characteristics and experiences of the Australian naturopathy and WHM workforce. Four electronic databases were searched: MEDLINE (via Ovid), AMED (via Ovid), CINAHL (via Ovid) and Embase (via Ovid). All fields for each database were searched using a combination of "naturopath$" and "Australia". Search results were downloaded and saved as .RIS files on 23 October 2020. Search files were imported to Covidence (Covidence) for filtering and data extraction.

Figure 5.1 shows the article selection process. Articles were included if they presented original research published in a peer-reviewed journal between 2010 and 2020. Included were articles about original research from observational studies including quantitative (e.g. survey) or qualitative (e.g. focus groups, interviews) methods that reported on the characteristics of the Australian naturopathic workforce and their approach and experience of practice. Articles were excluded if the Australian data were aggregated with data from other countries, or naturopathic workforce data were aggregated with data from other health professions.

Duplicates were identified and removed using the Covidence duplicate filter feature. Two researchers independently filtered the citations via title and abstract in accordance with the eligibility criteria. Any differences in classification were discussed between two researchers until consensus was reached. The full text of the retained citations were sourced and checked for eligibility by the lead author. Reference lists and citation trails of articles

retained after checking the full text were also checked to identify other relevant articles.

Data were extracted through Covidence Extraction 2.0 using a template developed by the lead author based upon similar previous systematic reviews. Extracted data were exported to a Microsoft Excel spreadsheet and then thematically categorised in separate tables in a Microsoft Word document.

Data from the included articles were categorised into themes and, where appropriate, compared with the results of the naturopathy/WHM workforce study published in the Lin Report (2005).

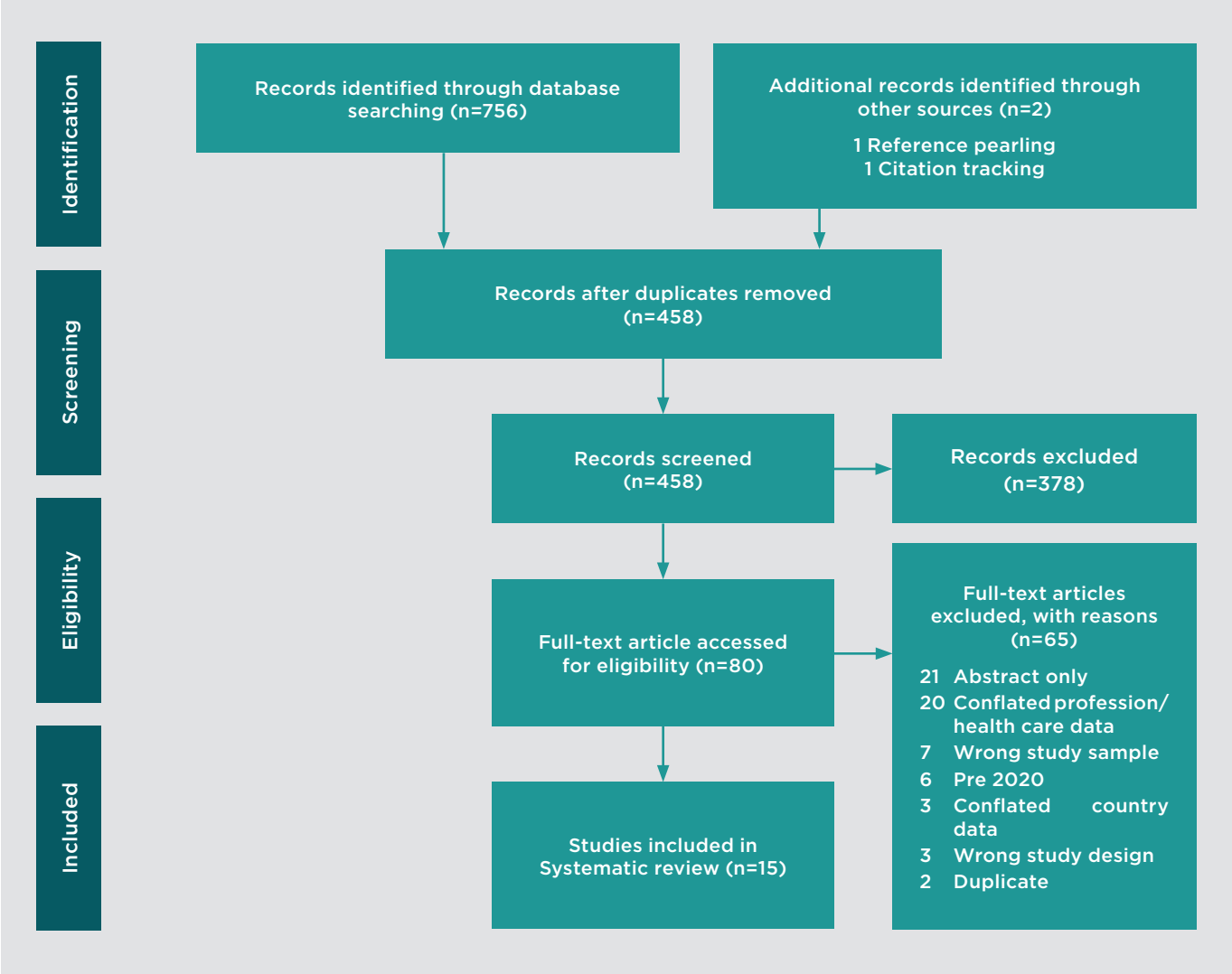

Figure 5.1: Article selection process and outcome

5.3 RESULTS

The database search identified 756 records of which 458 were not duplicates. After assessing against eligibility criteria and checking of reference lists and citation trails, 15 articles were identified for inclusion in the review (see Figure 5.1).

The included articles presented results from studies conducted using national (n=7) and regional (n=8) sample populations, and employing survey research (n=3), secondary analysis of existing databases (n=3), semi-structured interviews (n=8) and focus groups (n=1). Eleven of the 15 included studies focused specifically on the naturopathic profession, with the remainder combining data from naturopaths and herbalists. The details of the included articles are presented in Table 5.1. The results of the included articles were categorised according to five key themes: *Practitioner characteristics, Workplace and practice characteristics, Practice behaviours, Patient profile, and Professional and Interprofessional issues.*

Practitioner characteristics

Three studies presented results describing the characteristics of naturopaths (Braun et al., 2011; Leach 2013; Steel et al., 2020c) and one of these studies combined this data with the characteristics of WHM practitioners (Braun et al., 2011).

Table 5.1 presents an overview of the findings from these studies. In summary:

- Using 2006 Census data, Leach (2013) estimated there were 2982 naturopaths in Australia (Leach 2013).
- Three studies reported data on the gender distribution of the naturopathy workforce. The findings were broadly consistent across these studies: the majority of naturopaths and herbalists are female (79.0% (Leach 2013), 84% (Braun et al., 2011), 86.7% (Steel et al., 2020c)) and aged less than 60 years old (91.9% (Leach 2013), with a mean age 45.5 years (Steel et al., 2020c)).
- Two studies reported data on the qualifications of practitioners. Steel & colleagues (2020c) found less than half of the profession reported an undergraduate degree in naturopathy (Steel et al., 2020c), with Braun & colleagues finding 15% of practitioners reported a graduate diploma as their highest naturopathy and/or WHM qualification (Braun et al., 2011). Over one third of naturopaths reported a qualification in addition to their naturopathic qualification, the most common being: WHM (37.4%), nutrition (37.0%), or massage (34.9%) (Steel et al., 2020c).
- Two studies reported data from practitioners on their number of years in practice (Braun et al., 2011; Steel et al., 2020c). The most recent of these studies conducted by Steel & colleagues (2020c) reported the highest proportion of practitioners had been in practice for 20 years or more, although a substantial number were also in practice for less than 5 years (19.9%) or for 5 to 9 years (19.9%) (Steel et al., 2020c). Braun & colleagues (2011) found just under one third of practitioners had been in practise for between one and four years and a similar proportion in practice more than ten years.

Table 5.1: Characteristics of included studies, and thematic category of results reported in each study (A: Practitioner characteristics; B: Workplace and practice characteristics; C: Practice behaviours; D: Patient profile; E: Professional and interprofessional issues)

Author/s, date	Title	Study location	Setting	Study design	Profession definition	Sample population	Sample size	A	B	C	D	E
Braun et al. (2013)	Naturopaths' and Western herbalists' attitudes to evidence, regulation, information sources, and knowledge about popular complementary medicines	National	Online	Survey, cross-sectional	Naturopathy/ Herbal medicine	Naturopaths and WHM practitioners	479					✗
Braun et al. (2011)	The prevalence and experience of Australian naturopaths and Western herbalists working within community pharmacies	National	Online	Survey, cross-sectional	Naturopathy/ Herbal medicine	Naturopaths and WHM practitioners	479	✗	✗			✗
Leach (2013)	Profile of the complementary and alternative medicine workforce across Australia, New Zealand, Canada, United States, and United Kingdom	National	Other: Secondary analysis of Census data (2006)			Australian and New Zealand citizens	Total population	✗	✗		✗	
Malhotra et al. (2020b)	The perspective of Australian naturopaths about providing health services for people with sleep disorders	National	Other: PRACI	Qualitative, interviews	Naturopathy/ Herbal medicine	Naturopaths and WHM practitioners in current clinical practice	20			✗	✗	✗
Steel & Adams (2011a)	The interface between tradition and science: Naturopaths' perspectives of modern practice	Queensland	Clinic/health service	Qualitative, interviews	Naturopathy	Naturopaths in current clinical practice	12					✗
Steel & Adams (2011b)	Approaches to clinical decision-making: A qualitative study of naturopaths	Queensland	Clinic/health service	Qualitative, interviews	Naturopathy	Naturopaths in current clinical practice	12					✗
Steel & Adams (2011c)	The application and value of information sources in clinical practice: an examination of the perspective of naturopaths	Queensland	Clinic/health service	Qualitative, interviews	Naturopathy	Naturopaths in current clinical practice	12					✗
Steel et al. (2020b)	Australian Naturopaths' Approach to Caring for People with Cardiovascular Disease and Associated Risk Factors: A Qualitative Study of the Providers' Perspective	National	Other: PRACI	Qualitative, interviews	Naturopathy	Naturopaths in current clinical practice	10			✗		
Steel et al. (2020c)	The naturopathic profession in Australia: A secondary analysis of the Practitioner Research and Collaboration Initiative (PRACI)	National	Other: PRACI	Survey, cross-sectional	Naturopathy	Clinicians with naturopathic qualifications	155	✗	✗	✗	✗	✗
Wardle et al. (2013)	Current challenges and future directions for naturopathic medicine in Australia: A qualitative examination of perceptions and experiences from grassroots practice	Queensland	Clinic/health service	Qualitative, interviews	Naturopathy	Naturopaths practicing in a non-urban area	20					✗

Author/s, date	Title	Study location	Setting	Study design	Profession definition	Sample population	Sample size	A	B	C	D	E
Wardle et al. (2019)	Collaborating with medicine? Perceptions of Australian naturopaths on integrating within the conventional medical system	Queensland	Clinic/health service	Qualitative, interviews	Naturopathy	Naturopaths practicing in a non-urban area	20					✗
Wardle et al. (2010)	A qualitative study of naturopathy in rural practice: a focus upon naturopaths' experiences and perceptions of rural patients and demands for their services	Queensland	Clinic/health service	Qualitative, interviews	Naturopathy	Naturopaths practicing in a non-urban area	20				✗	
Wardle et al. (2011)	Distribution of complementary and alternative medicine (CAM) providers in rural New South Wales, Australia: A step towards explaining high CAM use in rural health?	New South Wales	Rural areas	Secondary analysis	Naturopathy	Membership lists from professional associations; State registration Board data; General practitioners listed on rural NSW Divisions of General Practice	All listed practitioners		✗			
Wardle & Adams (2013)	Are the CAM professions engaging in high-level health and medical research? Trends in publicly funded complementary medicine research grants in Australia	National	Other: Government data	Other: Document analysis	Naturopathy	NHMRC and ARC grant recipients	n/a					✗
Gerontakos et al. (2021)	Clinician perspectives and understanding of the adaptogenic concept: a focus group study with naturopaths and herbalists	Sydney, Melbourne, Brisbane	Educational institutions delivering accredited naturopathic degrees	Qualitative, focus groups	Naturopathy/ WHM	Naturopaths with advanced diploma of Naturopathy and/or WHM or a Bachelor of Health Science in Naturopathy and/or WHM, and a minimum of 5 years clinical experience	17					✗

PRACI: Practitioner Research and Collaboration Initiative

Table 5.2: Characteristics of naturopathic practitioners reported in included articles

Author (date)	Sample population	Results	
Braun et al. (2011)	Naturopaths and WHM practitioners (n=479)	Gender: Male (16%) Female (84%) Years spent working as a naturopath/WHM practitioner: Never (2.0%) <1yr (12.0%) 1-4 yr (30.0%) 5-9 yrs (22.0%) 10+ yrs (31.0%)	Highest level of qualification in naturopathy and/or WHM: Certificate (<1.0%) Advanced diploma (36.0%) Undergraduate degree (40.0%) Graduate diploma (15.0%) Master's degree (4.0%) PhD (1.0%)
Leach (2013)	Secondary analysis of Census data (2006)	Estimated number: 2982 Gender: Males: 21.0% Females: 79.0% Age: <40 yrs - 40.5% 40-59 yrs - 51.4% >=60 yrs – 8.1%	Highest education level: High school or certificate – 10.1% Diploma or advanced diploma – 42.7% Bachelor's degree – 34.9% Graduate diploma or certificate – 2.4% Postgraduate degree – 2.7% No qualification or not stated – 7.2%
Steel et al. (2020c)	Clinicians with naturopathic qualifications (n=155)	Gender: Female: 86.7% Age: 45.5 y (10.4; 44.3, 46.7) Years in full-time practice: 6.6 (10.2; 5.4, 7.8) Years in part-time practice: 8.2 (31.1; 4.5, 11.9) Naturopathic Qualifications*: Certificate – 3.6% Diploma – 11.0% Advanced diploma – 49.1% Bachelor's degree – 45.6%	Years since first qualification: Less than 5 yrs – 19.9% 5 to 9 years – 19.9% 10 to 14 yrs – 17.8% 15 to 19 yrs – 17.4% 20 yrs or more – 24.9% Other clinical qualifications: WHM – 37.4% Nutrition – 37.0% Massage – 34.9% Homeopathy – 17.1% Aromatherapy – 6.8% Acupuncture – 5.0% Chinese herbal medicine – 2.1%

*Participants may select more than one option.

Workplace and practice characteristics

Four studies presented findings on the workplace and practice characteristics of naturopaths (Braun et al., 2011; Leach 2013; Steel et al., 2020c; Wardle et al., 2011), their practice locations, practice hours, estimated average weekly income, and areas of clinical interest of practitioners.

Table 5.3 presents an overview of the findings from these studies. In summary:

- Two studies reported findings with respect to the location of practice of naturopaths. Using Census data, Leach (2013) found that 71% of naturopaths work in the industry of "medical and other health care service". Using survey data, Braun & colleagues (2011) found the average number of practitioners working in solo private practice was 38% (external clinic 22% and home-based clinic 16% (Braun et al., 2011)); and solo in all practices 45.7% (Steel et al., 2020c). They found practitioners spend between 15% and 52% of the work week in non-clinical roles (retail, technical expert, sales representative, lecturer, researcher, and group education) (Steel et al., 2020c).
- Wardle & colleagues (2011) reported on the number of naturopaths practising in rural and remote areas. They found 541 naturopaths practising in rural or remote New South Wales – an average of one naturopath for every three GPs and approximately 3000 people (Wardle et al., 2011). In some areas this ratio was almost one naturopath for every GP and 1000 people (Wardle et al., 2011).
- Steel & colleagues (2020c) reported on the practice hours of naturopaths. Using survey data, they estimated the average number of hours per week practitioners spend in naturopathic practice to be 17.6 (Steel et al., 2020c).

- Two studies estimated the average weekly income of naturopaths. Using 2006 Census data, Leach (2013) estimated average weekly income to be $1193.67. In a more recent study using data derived from direct surveys of the profession, Steel & colleagues (2020c) estimated average weekly income of naturopaths to be $1,837.44.
- Steel & colleagues (2020c) also reported on the areas of clinical interest of naturopaths. They found the most common areas of clinical interest among naturopaths (described in percentage of naturopaths indicating an interest in the area) were digestive conditions (84%) women's health conditions (79.4%), general health (76.2%), allergies (70.8%), endocrine disorders (70.5%), and mental health (68%) (Steel et al., 2020c).

Table 5.3: Workplace and practice characteristics of naturopaths reported in included studies

Author (date)	Sample population	Results	
Braun et al. (2011)	Naturopaths and WHM practitioners	Current main place of practice: Multidisciplinary clinic with other CM practitioners (29.0%), Multidisciplinary clinic with medical practitioners (4.0%), Naturopathy/herbal medicine clinic as a solo practitioner (22.0%), Home-based clinic (16.0%), In a pharmacy (7.0%), In industry, e.g. sales representative (8.0%), Not currently in practice (5%), Other (19%); Pharmacy experience: Had worked in community pharmacy at some time in the past (24%) The majority of naturopaths working in a pharmacy (75%) had done so for less than 5 years.	Naturopaths from pharmacy only Roles and practice in pharmacy: specialist CM product sales (81%), short consultations in pharmacy (68%), long consultations in private room (57%), provided staff education (56%), undertook general product sales (45.5%); Access to product in pharmacy: held a large variety of specialty products (26%), had a limited range of specialty products (23%), did not have their own practitioner products (25%); Types of product stocked in pharmacy: Stocked practitioner-only complementary medicine products (44.0%), Had liquid herbal medicines in the pharmacy (34%);
Leach (2013)	Secondary analysis of Census data (2006)	Number of hours worked per week (may not be limited to naturopathic practice): 0hr – 3.4% 1-16hr – 24.7% 17-34 hr – 31.7% >=35 hr – 38.0% Not stated – 2.2% Average gross weekly income: $0-999 – 87.7% $1000-1999 – 9.7% >=$2000 – 1.5% Not stated – 1.2%	Industry of employment: Medical and other health care service – 71.0% Hospital – 0.2% Residential care service – 0.2% Social assistance service – 1.0% Other health/social service – 3.9% Other industry – 22.7% Not stated – 1.1%
Steel et al. (2020c)	Clinicians with naturopathic qualifications	Average days per week in practice: 3.6 (3.8; 3.1, 4.0) Average hours per week in practice: 17.6 (18.2; 15.5, 19.8) Average clients per week: 12.2 (10.2; 10.9, 13.4) Average new clients per month: 26.6 (125.1; 11.7, 41.5) Average hourly rate: $104.40 (35.1; 100.1, 108.6) Solo group practice arrangements: Solo in at least one practice – 26.8% Solo in all practices – 45.7% No solo practices – 27.5% Digital health: Online consultations: 61.3% Phone consultations: 61.0%	Percentage of work week in non-clinical roles: Retail – 48.2 (24.1; 10, 100) Technical expert – 33.0 (29.6; 0.3-90) Sales representative – 52.1 (27.1; 5, 80) Lecturer – 31.0 (25.4; 1, 100) Researcher – 33.5 (27.8; 5, 80) Group education – 15.3 (18.2; 2, 100) Clinical interest topics: Digestive conditions – 84.0% Women's health – 79.4% General health – 76.2% Allergy – 70.8% Endocrine – 70.5% Mental health – 68.0% Weight management – 65.5% Complex conditions – 64.1% Skin – 63.0% CVD – 54.1% Men's health – 51.6% Respiratory – 51.6% Musculoskeletal health – 50.9% Pain – 50.5% Paediatrics – 49.5% Ear-nose-throat – 47.0% Oncology – 41.3% Renal – 40.2% Sports performance and recovery – 38.8% Gerontology – 26.0%

Author (date)	Sample population	Results	
Wardle et al. (2011	Membership lists from professional associations; State registration Board data; General practitioners listed on rural NSW Divisions of General Practice	Number of naturopaths per Division of General Practice in regional and remote New South Wales (Naturopath:GP /Naturopath:Population): Total: 541 (1:2.8/1:2929)	
		Barrier: 3 (1:6/1:8144) Barwon: 4 (1:11/1:13 904) Dubbo-Plains: 12 (1:6/1:8280) Hastings McLeay: 26 (1:4/1:3648) Hunter Rural: 65 (1:3/1:3082) Mid-North Coast: (54 (1:2/1:2331) Murrumbidgee: 13 (1:4/1:4880) New England: 15 (1:4/1:4277) NSW Central West: 39 (1:3/1:4364)	NSW Outback: 3 (1:5/1:5684) NSW Southern: 63 (1:3/1:2786) North West Slopes: 10 (1:5/1:5998) Northern Rivers: 138 (1:1/1:1151) Riverina: 22 (1:4/1:5231) Shoalhaven: 35 (1:3/1:2499) Southern Highlands: 28 (1:2/1:1730) Tweed Valley (only rural and remote locations): 11 (1:2/1:2182)

Practice behaviours

Four of the included articles presented findings concerning naturopaths' practice behaviours (Malhotra et al., 2020b; Steel et al., 2020b; Steel et al., 2020c; Wardle et al., 2011) and one of those studies included data from WHM practitioners as well as naturopaths (Malhotra et al., 2020b).

Table 5.4 presents an overview of the findings from these studies on practice behaviours. In summary:

- Steel & colleagues (2020c) found the most frequent diagnostic or health assessment techniques used by naturopaths included:
  - pathology tests (used by 90.2% of naturopaths)
  - patient symptom diary (87.7%)
  - nail inspection (57.1%)
  - a pre-intake health history form (54.7%)
  - physical inspection and palpation (43.1%) and
  - clinical information from another health professional (42.3%) (Steel et al., 2020c)
- Malhotra & colleagues (2020b) provided detailed description of the naturopathic consultation process, treatment approach, and treatment models in the context of provision of treatment for sleep disorders (Malhotra et al., 2020b). They found that naturopaths and herbalists reported making tailored treatment plans for their patients and initiating treatments with lifestyle-related and dietary changes (Malhotra et al., 2020b).
- Steel & colleagues (2020c) reported on topics that naturopaths discussed with their patients, the treatments prescribed to patients, and diagnostic techniques used (Steel et al., 2020c). They found other topics most frequently reported as "often" discussed by naturopaths with patients (described by percentage of naturopaths answering "often") included sleep (90.2%), stress management (85.3%), physical activity and fitness (79.4%), medication/ pharmaceuticals (60%), substance use (58.1%) and counselling and mental health (57%) (Steel et al., 2020c). Treatments most frequently described as "often" prescribed by naturopaths included lifestyle prescription (86.8%), herbal tablets (74.1%), nutritional supplements (79.3%), liquid herbal medicines (69.2%) and specific diets (62.8%) (Steel et al., 2020c). Steel & colleagues (2020b) reported on the naturopathic approach to management of patients with cardiovascular disease (CVD). They found 91% of naturopaths reported diet and nutrition was a topic "often" discussed with patients.
- With respect to interprofessional practice, naturopaths and herbalists reported that an integrated treatment approach would be ideal, to improve safety of combined conventional and complementary therapies but reported poor integration due to multiple barriers to establishing integrated models including the absence of statutory regulation (Malhotra et al., 2020b).
- Steel & colleagues (2020b) also found naturopaths reported barriers to GP referral in the management of patients with CVD and believed statutory registration may address this challenge (Steel et al., 2020b).

Table 5.4: Naturopathic practitioners' practice behaviours reported in included studies

Author date	Sample population	Results		
Steel et al. (2020c)	Clinicians with naturopathic qualifications	Topics discussed with patients: Diet and nutrition: Never – 1.9% Rarely – 0.6% Sometimes – 6.4% Often – 91.1% Sleep: Never – 0.0% Rarely – 0.0% Sometimes – 9.8% Often – 90.2% Stress management: Never – 0.0% Rarely – 1.3% Sometimes – 13.5% Often – 85.3% Physical activity and fitness: Never – 0.0% Rarely – 2.6% Sometimes – 18.1% Often – 79.4% Medication/pharmaceuticals: Never – 4.5% Rarely – 5.2% Sometimes – 30.3% Often – 60.0% Substance use (tobacco, alcohol, illicit): Never – 1.3% Rarely – 9.0% Sometimes – 31.6% Often – 58.1% Counselling and mental health: Never – 0.0% Rarely – 5.8% Sometimes – 37.2% Often – 57.0% Occupational health and safety: Never – 11.8% Rarely – 39.2% Sometimes – 36.0% Often – 13.1% Surgical interventions: Never – 7.6% Rarely – 40.3% Sometimes – 43.7% Often – 8.4% Vaccination: Never – 8.4% Rarely – 54.6% Sometimes – 31.1% Often – 5.9%	Treatments prescribed to patients Lifestyle prescription: Never – 0.0% Rarely – 0.8% Sometimes – 12.4% Often – 86.8% Treatments prescribed to patients Lifestyle prescription: Never – 0.0% Rarely – 0.8% Sometimes – 12.4% Often – 86.8% Herbal tablets: Never – 0.0% Rarely – 9.3% Sometimes – 16.7% Often – 74.1% Nutritional supplements: Never – 1.9% Rarely – 0.0% Sometimes – 18.5% Often – 79.3% Liquid herbal medicines: Never – 3.3% Rarely – 8.3% Sometimes – 19.2% Often – 69.2% Specific diets: Never – 1.7% Rarely – 8.3% Sometimes – 27.3% Often – 62.8% Relaxation exercises: Never – 2.5% Rarely – 10.8% Sometimes – 42.5% Often – 44.2% Exercise prescription: Never – 1.7% Rarely – 15.8% Sometimes – 40.0% Often – 42.5% Meditation: Never – 2.5% Rarely – 8.3% Sometimes – 47.9% Often – 41.3% Compound nutritionals: Never – 13.3% Rarely – 20.8% Sometimes – 29.2% Often – 36.7% Yoga: Never – 6.6% Rarely – 18.2% Sometimes – 48.8% Often – 26.5% Celloids and tissue salts: Never – 20.8% Rarely – 35.0% Sometimes – 28.3% Often – 15.8% Topical medicines: Never – 3.3% Rarely – 25.8% Sometimes – 56.7% Often – 14.2%	Dried herbs (e.g. infusions): Never – 9.2% Rarely – 43.3% Sometimes – 35.0% Often – 12.5% Commercial homeopathic remedies: Never – 30.5% Rarely – 33.1% Sometimes – 26.3% Often – 10.2% Specific homeopathic remedies: Never – 55.0% Rarely – 22.5% Sometimes – 15.0% Often – 7.5% Neti pots: Never – 43.8% Rarely – 33.9% Sometimes – 15.7% Often – 6.6% Hydrotherapy: Never – 45.0% Rarely – 34.2% Sometimes – 17.5% Often – 3.3% Ear candling: Never – 58.7% Rarely – 32.2% Sometimes – 8.3% Often – 0.8% Colonics: Never – 67.5% Rarely – 21.7% Sometimes – 10.8% Often – 0.0% Diagnostic or health assessment techniques used: Pathology tests – 90.2% Patient symptom diary – 87.7% Nail inspection – 57.1% Pre-intake form – 54.7% Observation – 48.7% Health history – 47.7% Patient-reported outcome measures – 43.5% Physical examination and palpation – 43.1% Iridology – 42.9% Inspection – 42.4% Clinical information from another health professional – 42.3% Tongue diagnosis – 42.3% Validated assessment instruments – 27.9% Hair testing – 27.9% Postural/structural assessment – 24.2% Radiological tests – 23.1% Bio-impedance analysis – 13.2% Live blood analysis – 11.1% Kinesiology – 11.0% Energy-testing machine – 6.9%

Author date	Sample population	Results
Steel et al. (2020b)	Naturopaths in current clinical practice	***Approach to management of CVD patients*** ***Coordination and integration of care*** – participants described attempts to coordinate with other care providers, primarily general practitioners (GPs) who were also involved in providing care to the patient. Reasons for attempts were patient safety and to communicate respect for the role of all health professionals involved with the patient. Almost all participants described difficulties in enacting interprofessional communication. ***Access to care*** – participant perceptions of patient challenges to accessing naturopathic for CVD: poor GP understanding of naturopathic treatments used alongside pharmaceuticals viewed as presenting a barrier to GP referral; GP perception that the training of naturopaths is insufficient for naturopaths to deliver safe and effective care; belief that statutory registration may address this challenge. ***Continuity of care*** – described practice behaviours aimed to support continuity of care and appropriate care transition for individuals accessing their services. ***Information and education*** – providing patients with information to facilitate autonomy, self-care, and health promotion. ***Respect for patients' values, preferences, and expressed needs*** – included recognising the patient as an individual with their own unique values and preferences. ***Involvement of family and friends*** – the focus was on the naturopath accounting for the impact of changes in the patients' health behaviours on their social networks, and vice versa. ***Continuity and transition*** – practice behaviours aimed to support continuity of care and appropriate care transition for individuals accessing their services, providing information to patients regarding how best to access other services, providing instructions on how to self-monitor changes in response to treatment, attempts to facilitate effective transition to care from other health professionals (particularly medical doctors).
Malhotra et al. (2020b)	Naturopaths and herbal medicine practitioners in current clinical practice	***Getting to know the patient and their problem:*** Very detailed case histories including investigating lifestyle factors and social history prior to exploring the presenting complaint. ***Tailored treatments:*** Initiated their treatment with lifestyle-related/dietary changes in a patient's daily routine. If this was unsuccessful practitioners would draw on other treatments including – herbal moieties, mineral supplements, hormones, homeopathic melatonin, hypnotherapy, psychological treatments, and other approaches. ***Collaborative treatment models:*** Emphasized that integrated treatment approach would be ideal, by improving adherence to recommended treatments and enhancing safety of combined conventional and complementary treatments. Poor integration due to lack of GP understanding of the efficacy of naturopathic treatments, and the absence of statutory regulation, and the associated lack of a well-defined curriculum or a standard training competencies framework akin to those in conventional health care disciplines was also a barrier to establishing integrated models. Practitioners saw less importance in collaborating with pharmacists as they felt confident they could navigate drug-herb/drug-nutrient interactions themselves.

Profile of patients treated

Three of the included articles presented data on the profiles of patients and populations treated by naturopaths and herbalists (Malhotra et al., 2020b; Steel et al., 2020c; Wardle et al., 2010).

Table 5.5 presents an overview of key findings from these studies. In summary:

- Steel & colleagues (2020c) reported on populations and conditions treated by naturopaths. They identified the populations most frequently reported as "often" treated by naturopaths included middle age (88.5%), adolescents (45.2%) and older people (34.4%). Naturopaths reported treating children "sometimes" (52.6%) and pregnant women "sometimes" (45.9%) or "often" (24.2%).

The conditions most frequently reported as "often" treated by naturopaths included:

  - fatigue (95%)
  - digestive disorders (83.7%)
  - anxiety and depression (77.4%)
  - irritable bowel syndrome (IBS) (66.9%)
  - menstrual disorders (61%) and
  - sleep disorders (60.5%) (Steel et al. 2020c).

- Other conditions reported to be treated "often" by naturopaths included thyroid complaints (46.7%), chronic pain (38.8.%), headache/migraine (38.7%), recurrent infections (37.5%) and arthritis (31.2%).
- Wardle & colleagues (2010) examined naturopathy in rural health (Wardle et al., 2010). They found that rural patients and populations have an affinity with naturopathy in that they prefer a preventative approach to health, they favour self-care, and they appreciate the time commitment and support provided by their naturopaths.
- Malhotra & colleagues (2020a) addressed patient drivers for seeking naturopathic care for sleep disorders. They found that patients have an inherent belief in the benefits of complementary treatment approaches and often use conventional medicines concurrently.

Table 5.5: The profile of patients consulting naturopathic practitioners reported in included studies

Author (date)	Sample population	Results			
Steel et al. (2020c)	Clinicians with naturopathic qualifications	Populations treated: Infant/toddler: Never – 9.1% Rarely – 47.1% Sometimes – 32.2% Often – 11.6% Children: Never – 3.9% Rarely – 31.4% Sometimes – 52.6% Often – 12.2% Adolescents: Never – 1.9% Rarely – 19.1% Sometimes – 33.8% Often – 45.2% Middle age: Never – 0.0% Rarely – 0.0% Sometimes – 11.5% Often – 88.5% Older people: Never – 1.3% Rarely – 19.8% Sometimes – 44.6% Often – 34.4% Elite athletes: Never – 39.4% Rarely – 45.8% Sometimes – 12.3% Often – 2.6% Pregnant women: Never – 5.1% Rarely – 24.8% Sometimes – 45.9% Often – 24.2%	Veterans: Never – 44.9% Rarely – 38.5% Sometimes – 14.7% Often – 1.9% First Nations: Never – 44.0% Rarely – 47.1% Sometimes – 8.9% Often – 0.0% Non-English speaking ethnic: Never – 37.4% Rarely – 40.7% Sometimes – 18.7% Often – 3.2% Conditions treated Fatigue: Never – 0.0% Rarely – 0.0% Sometimes – 5.0% Often – 95.0% Digestive disorders: Never – 0.0% Rarely – 0.0% Sometimes – 16.3% Often – 83.7% Anxiety/depression: Never – 1.3% Rarely – 3.9% Sometimes – 17.4% Often – 77.4%	IBS Never – 0.0% Rarely – 4.1% Sometimes – 28.9% Often – 66.9% Menstrual disorders: Never – 0.0% Rarely – 7.3% Sometimes – 31.7% Often – 61.0% Sleep disorders: Never – 1.3% Rarely – 4.5% Sometimes – 33.8% Often – 60.5% Thyroid complaints: Never – 1.7% Rarely – 10.8% Sometimes – 40.8% Often – 46.7% Chronic pain: Never – 0.8% Rarely – 14.1% Sometimes – 46.3% Often – 38.8% Headache/migraine: Never – 0.0% Rarely – 4.5% Sometimes – 56.8% Often – 38.7% Recurrent infections: Never – 0.0% Rarely – 8.3% Sometimes – 54.2% Often – 37.5%	Arthritis Never – 2.6% Rarely – 15.6% Sometimes – 50.7% Often – 31.2% Eczema/psoriasis: Never – 0.0% Rarely – 20.5% Sometimes – 57.4% Often – 22.1% Hay fever: Never – 0.8% Rarely – 15.8% Sometimes – 64.2% Often – 19.2% ADHD/Autism/Learning difficulties: Never – 11.5% Rarely – 41.0% Sometimes – 32.8% Often – 14.6% Asthma: Never – 3.3% Rarely – 44.6% Sometimes – 43.8% Often – 8.3% Drug/alcohol addiction: Never – 14.6% Rarely – 47.2% Sometimes – 34.2% Often – 4.1% Dementia/ Alzheimer's: Never – 31.4% Rarely – 52.9% Sometimes – 13.2% Often – 2.5%
Wardle et al. (2010)	Naturopaths in current clinical practice	***Explaining the affinity for naturopathy in rural health:*** Affinity with rural patients and populations (1) Rural patients have an 'open-minded' and 'independent' outlook or approach. (2) Stoic approach which preferences preventive measures and self-care. (3) Preventive and empowering tenets of naturopathy suits constraints and logistics of rural life. (4) Time commitment and support of naturopathy is appealing. (5) Close personal relationships in rural communities cement demand. (6) Naturopaths often originally from the area they practiced in, which is appealing to the local community and contrasts with many medical doctors practicing rurally. ***Barriers and challenges to naturopathy use in rural health:*** (1) Resourcefulness and independence of rural people may produce challenges in timely treatment for all health professionals but amplified for naturopaths due to out-of-pocket costs. (2) Rural patients need to feel in control and be central to decision-making.			
Malhotra et al. (2020b)	Naturopaths and herbal medicine practitioners in current clinical practice	Patient drivers for seeking naturopathic care for sleep disorders: Believed to be due to an inherent belief in the benefits of complementary treatment approaches, or because their initial experience with conventional medicines was unsatisfactory. Patients often also using conventional medicines.			

Professional and interprofessional issues

Ten of the included articles presented data describing professional and interprofessional issues (Braun et al., 2013; Gerontakos et al., 2021; Malhotra et al., 2020b; Steel & Adams, 2011a; Steel & Adams, 2011; Steel & Adams, 2011b; Steel et al., 2020c; Wardle & Adams, 2013; Wardle et al., 2017; Wardle et al., 2013) and three of those studies included data for both naturopaths and herbalists (Braun et al., 2013; Gerontakos et al., 2021; Malhotra et al., 2020b).

Table 5.6 presents an overview of key findings from these studies. Professional and interprofessional issues addressed in these studies included:

- the information sources used by naturopaths and their information preferences (Braun et al., 2013; Gerontakos et al., 2021; Steel & Adams 2011a; Steel & Adams 2011; Steel & Adams 2011b)
- attitudes of naturopaths towards statutory registration (Braun et al., 2013; Malhotra et al., 2020b; Steel et al., 2020c; Wardle et al., 2013), and
- challenges faced by the naturopathic profession (Malhotra et al., 2020b; Wardle et al., 2017; Wardle et al., 2013).

In summary:

- Using data derived from a document analysis of government data, Wardle & Adams (2013) found that naturopaths are active in research and successful with competitive funding awards. Compared with other CM professions, a greater proportion of NHMRC grants have been awarded to chief investigators with a clinical background as a naturopath: 5% of 134 NHMRC grants exploring CAM awarded to naturopaths, 7% to traditional Chinese medicine investigators and 1-2% to chiropractors; with no other CM professions awarded NHMRC grants.
- Three studies reported on the information sources used by naturopaths in their practice (Braun, 2012; Steel & Adams 2011 Part A; Steel & Adams 2011 Part B). Information sources considered important to naturopaths include complementary medicine textbooks (Braun et al., 2013; Steel & Adams, 2011a), professional seminars, journals, databases (Braun et al., 2013), manufacturer literature (Braun et al., 2013; Steel & Adams 2011a) (also considered not trustworthy (Steel & Adams 2011a)), internet sources (Braun et al., 2013; Steel & Adams 2011a) (also considered unreliable (Steel & Adams 2011a)).
- Naturopathic practitioners also considered interpersonal interactions (Steel & Adams 2011a), clinical experience and intuition (Steel & Adams, 2011) of importance in clinical applications.

With respect to the views of naturopaths concerning the role of traditional knowledge:

- Several studies found that naturopaths emphasised the importance of traditional knowledge and consider well-documented traditional/historical sources essential or important (Braun et al., 2013; Steel & Adams 2011b).
- Steel & Adams (2011b) found that naturopaths considered traditional knowledge as a valid information source in the absence of modern science and a resource to direct research.

With respect to collaboration with other practitioners:

- Braun & colleagues (2013) found that naturopaths also sourced information through referral and from other health providers, with exchange between naturopaths and pharmacists bi-directional – naturopaths referring to pharmacists for drug (93%), safety (72%), and medical information (55%) and pharmacists referring to naturopaths for product (85%), therapy, or dietary information (77%).
- Most naturopaths perceived the need for access to conventional health providers (80% “definitely”) (Steel et al., 2020c) and reported challenging experiences of collaborating with medicine (Wardle et al., 2017).

With respect to questions about regulation of naturopathy/WHM practice:

- Several studies found the majority of naturopaths (75.2% average (85% agree or strongly agree (Braun et al., 2013); 65.4% definitely (Steel et al., 2020c)) believed the profession should be formally registered to safeguard the public.
- Wardle & colleagues (2013) found that division and fragmentation of the naturopathic profession along with commercialisation and co-option of the naturopathic title by unqualified persons were considered current professional challenges by naturopaths, and regulation was seen as the core solution to these challenges.
- Malhotra & colleagues (2020b) found that while naturopaths felt competent in navigating drug-herb/drug-nutrient interactions, they believed the absence of statutory regulation was associated with issues of safety in combined conventional and complementary treatments, and poor integration with GPs and conventional medicine.

Table 5.6: Professional and interprofessional issues experienced by naturopaths as reported in included studies

Author (date)	Results	
Braun et al. (2013a)	Attitudes towards statutory registration: Naturopaths/WHM practitioners should be formally registered to safeguard the public: Strongly agreed: 58% Agreed: 27% Unsure: 8% Disagreed or Strongly disagreed: 8% Recent graduates more commonly Strongly Agreed (p=0.0045) Less recent graduates more commonly Agreed (p=0.03) Information sources used: CM textbooks (74%) Professional seminars, conferences (67%) CM journals (57%) Databases (e.g. MEDLINE) (48%) Manufacturer literature (43%) Drug reference books (33%) Peer-reviewed medical journals (29%) CM practitioners (26%) Specific websites (24%) World wide web (e.g. Google) (17%) Factors important when assessing information resources: Contains traditional and scientific information (82%) Updated frequently (52%) Had a scientific basis (50%) Contained information about a wide range of CMs – with and without evidence (39%)	More recent graduates wanted information to be: available on their desktops (29% vs 20%, p=0.025); available at no cost (11% vs 6%, p=0.05) not produced by manufacturers (20% vs 13%, 0.04) Information sources considered essential or important: Well-documented traditional/historical use (99%) Patient reports or feedback (97%) Personal experience (97%) Randomised controlled clinical trial with humans (94%) Published case studies (89%) Epidemiological studies (84%) Importance of RCTs as information sources: Recent graduates (<5 yrs) more commonly thought RCTs essential compared to others (33% vs 21%, p=0.003). Older graduates more commonly rated them as important (52% vs 43%, p=0.05) No other significant differences. Information exchange: Pharmacists referred to the naturopathy/WHM practitioner for: CM product information (85%), information about other complementary therapies or dietary information (77%), to provide customer service (77%) Practitioners referred to pharmacists for: drug information (93%), safety and drug interaction information (72%), medical information (55%).
Steel and Adams (2011a)	(1) What is traditional knowledge: Disparate definitions of traditional knowledge including antique texts, oratory knowledge from lecturers, and recently published texts with content drawn from ancient texts. (2) Validity of traditional knowledge: Authentic information source even in the absence of modern research. (3) Validity and value of research: Affected by clinical transferability and absence of available research. Undermined by bias. (4) Science supports traditional knowledge: research was providing traditional knowledge. (5) Science undermines traditional knowledge: A focus on research was devaluing and eroding the role of traditional knowledge in modern practice. (6) Linking science and tradition: Traditional knowledge can be used to direct research, and science can be used to explain traditional knowledge.	
Steel and Adams (2011b)	Intuition, clinical experience and deductive reasoning: bridging the gap (1) Intuition: recognised as an important component within clinical decision-making. (2) Clinical experience: Affected the value placed on other information through more conventional sources. (3) Deductive reasoning: Illustrated most commonly in circumstances of perceived weakness in either the traditional information sources or scientific research.	
Steel and Adams (2011c)	***Information sources in naturopathic clinical practice:*** Critical appraisal and the need for self-directed research Textbooks as a source for specific information Internet is an important source of information, but the reliability and validity of the information is inconsistent and uncertain Manufacturers are useful but not trustworthy Formal education varies due to variability in lecturers' knowledge and skills Interpersonal interactions are useful when working through complex or contradictory information and applying it to clinical reality Limitations to using information sources primarily relate to access and understanding of research.	
Wardle and Adams (2013)	Of 134 NHMRC grants awarded exploring CAM between 2000 and 2013, 5% of chief investigators had a clinical background as a naturopath. The only other NHMRC grants with CM practitioners as chief investigators were TCM (7%) and chiropractor (1-2%). The first NHMRC grant awarded to naturopathic chief investigators was in 2009.	

Author (date)	Results	
Steel et al (2020c)	***Perceived need for future access to statutory registration:*** No – 3.3% Unsure – 7.2% Maybe – 24.2% Definitely – 65.4% ***Perceived need for future access to:*** Conventional health providers: No – 0.0% Unsure – 3.4% Maybe – 16.0% Definitely – 80.7% Hospitals and other health settings: No – 0.8% Unsure – 5.7% Maybe – 28.7% Definitely – 64.8%	***Medicare rebates:*** No – 5.9% Unsure – 5.1% Maybe – 17.7% Definitely – 71.4% ***Profession-specific postgraduate specialisation degrees:*** No – 1.7% Unsure – 5.0% Maybe – 11.7% Definitely – 81.7% ***Access to restricted herbs:*** No – 0.8% Unsure – 9.8% Maybe – 36.1% Definitely – 53.3%
Wardle et al. (2013)	***Challenges faced by the naturopathic profession:*** Misconceptions and erosion of the naturopathic philosophy. Pressure to move towards an evidence-based paradigm. The commercialisation of CAM. Division and fragmentation of the naturopathic profession. Co-option of the naturopathic title by unqualified persons. Proposed solutions – regulation seen as the core solution to many of the profession's problems.	
Wardle et al. (2019)	***Experiences of collaborating with medicine:*** Competing paradigms and the co-option of complementary medicine by conventional medicine practitioners. The protection of separate complementary and conventional medical worlds by patients and providers Biases created by doctors through selective experience and information. Interaction with the medical community described as indifferent, reactive, and one-sided.	
Malhotra et al, (2020b)	***Collaborative treatment models:*** Emphasised that integrated treatment approach would be ideal by improving adherence to recommended treatments and enhancing safety of combined conventional and complementary treatments. Poor integration due to lack of GP understanding of the efficacy of naturopathic treatments, and the absence of statutory regulation and the associated lack of a well-defined curriculum or a standard training competencies framework akin to those in conventional health care disciplines were also barriers to establishing integrated models. Practitioners saw less importance in collaborating with pharmacists as they felt confident they could navigate drug-herb/drug-nutrient interactions themselves.	
Gerontakos et al. (2021)	***Practitioner understanding and use of adaptogenic herbal medicines:*** Ambiguous cultural origins and divergent perceptions on sources of knowledge on adaptogens. Improving vitality and having a restorative effect. Inter-system activity. Comparison of clinician experience with literature review findings of researcher and laboratory evidence – found some overlap but many inconsistencies.	

5.4 DISCUSSION

The research published since the Lin Report was released in 2005 shows that some features of the naturopathic and WHM workforce and practice have changed while others have remained consistent over time.

First, this review confirms previous findings from the Lin Report that naturopaths in Australia are operating as primary care clinicians, providing care to diverse populations with varied health conditions, including vulnerable or marginalised communities (Department of Health, 2021). In some rural areas, the evidence suggests naturopaths represent up to one third of primary care practitioners, with some locations showing a similar ratio of naturopaths as general practitioners (Wardle et al., 2011).

Naturopaths engage with their patients in a range of areas important for health including diet and nutrition, mental health, substance use, and, in some instances, vaccination. This important role in primary care means that provision of inaccurate or misleading information can undermine important public health messaging and present significant risks to the community (Swire-Thompson & Lazer 2020; van der Meer & Jin 2020). It is imperative that naturopaths are properly trained to work as primary care clinicians and are well integrated within the broader primary care and public health systems.

Second, this review confirms previous findings from the Lin Report that while naturopathy is a multi-modality practice employing an eclectic range of practices, naturopaths frequently prescribe ingestive medicines in their practice, most commonly herbal medicines and nutritional supplements.

While some practitioners solely use WHM, the practice of WHM is core to the practice of naturopathy. Survey data suggests that over one third of naturopaths hold qualifications in WHM, almost all naturopaths prescribe herbal medicine products 'sometimes' or 'often' (Steel et al., 2020c), and naturopaths spend a greater proportion of their time practising herbal medicine than any of the other types of therapies (43.7%) (Bensoussan, Myers, Wu & O'Connor 2004: 19). This finding is supported by other data sources:

- the naturopathic professional associations recognised by the World Naturopathic Federation in Australia and New Zealand include both naturopaths and herbalists in their membership (Australian Naturopathic Council 2021; Naturopaths and Medical Herbalists of New Zealand 2019)
- international workforce data shows that herbal medicine is one of the most commonly used treatment modalities for naturopathic practice (Steel et al., 2020a) and is commonly taught in naturopathic programs
- Analysis of traditional and contemporary naturopathic texts identifies herbal medicine as the only treatment which has both a long history of use and continued inclusion in contemporary naturopathic texts; while additional nutritional qualifications were reported by a similar proportion of naturopaths, including of these treatments in naturopathic texts is more recent.

Widespread use of ingestibles as a core modality of naturopathic practice increases the risk profile of the profession (Bensoussan & Myers 1996), (Byard et al., 2017). Some products are categorised as scheduled poisons under therapeutic goods legislation (Avila et al., 2020), and unscheduled products also present risks to some populations (Di Lorenzo et al., 2015; World Health Organization 2018), requiring qualified practitioner oversight to ensure their use is appropriate and safe (Chinese Medicine Board of Australia 2015). These issues are discussed further in **Chapters 3** and **10**.

Third, this review confirms previous findings from the Lin Report that the principal model of practice adopted by naturopaths and herbalists is solo private practice. This also has implications for the risk profile of the profession and public safety. Quality assurance mechanisms that are often found in group practices, such as clinical governance systems and credentialling, are likely to be limited or absent in solo practice (Patel & Sharma 2021).

In the registered health professions, there is evidence that practitioners in solo practice are more highly represented in complaints and more likely to engage in unprofessional conduct compared with those who are embedded in an organisation or system, working alongside colleagues and peers (Medical Board of Australia 2024: 5).

Practitioners in solo practice generally have fewer opportunities to access peer networks to discuss and navigate challenging clinical issues (Foronda et al., 2016) or engage in interprofessional collaboration and coordinated team care (Lamb et al., 2011; O'Daniel & Rosenstein 2008). Organisations with strong clinical governance, such as supervisory structures, organisational hierarchy, policies, and peer-champions (Brownson et al., 2017; Rubio-Valera et al., 2014), are more likely to support evidence-based clinical practice and to identify unsafe or ineffectual practices more quickly. The absence of these QA mechanisms for naturopaths and herbalists in solo practices would be expected to limit quality improvement activities and practice changes that benefit patients (Steel et al., 2018).

Fourth, this review finds that naturopaths and herbalists access and use published research literature to inform their clinical practice and are well-represented among the allied health professions undertaking federal government funded research in Australia. Internationally, the naturopathic research community has produced more than 2000 research articles across a broad range of health conditions and treatment topics (Steel et al., 2021). The reported challenges naturopaths face in applying research evidence to clinical decisions are shared by other health professions and have led to research

effort directed towards improving the translation and implementation of new research into clinical practice more generally (Brownson et al., 2017; Steel et al., 2021; Steel et al., 2023). The included research describing the naturopathic workforce also suggests naturopaths use other information sources, but there are differences in the knowledge they seek from, and limitations they perceive for, each type of information source. This view reflects growing discussions in health research regarding the authority of knowledge generation, use and sharing within clinical practice (Adams et al., 2019; Cooper & Levin, 2010). It also suggests that the naturopathy & WHM professions require support in accessing and applying knowledge from various sources, but that this support should be relevant to the specifics of naturopathic professional culture and practice rather than simply employing mechanisms used for other health professions (Adams et al., 2019; Steel et al., 2018; Steel et al., 2021a; Steel et al., 2023).

Fifth, with respect to the qualifications of practitioners, although bachelor's degree qualifications in naturopathy and WHM have been available in Australia for more than 20 years, the data suggests that between 2011 and 2020, the proportion of naturopaths with Advanced Diploma qualifications increased from one third to almost half of the profession.

The continued availability of advanced diploma training in naturopathy is of concern (Breakspear, 2013), given that since 1997, the Australian and New Zealand Standard Classification of Occupations (**ANZSCO**) has listed the skill level for the naturopathic profession as 'Level 1', that is, commensurate with a bachelor's degree or higher (Australian Bureau of Statistics, 1997). According to the ANZSCO, this is the level of skill that is typically required to competently perform the tasks of the naturopathy profession (see ANZSCO **website**). Also, in December 2015, advanced diploma qualifications in naturopathy and WHM were removed from the Health Training Package, because degree level was considered by government to be the appropriate qualification standard (see **Chapter 6**).

Despite these policy decisions, in the absence of an enforceable minimum degree level qualification for entry to practice in the profession, one professional association has continued to accept unaccredited advanced diplomas as a qualification for membership (Le Breton 2014; ATMS 2023; Switch on Health 2023). Some argue that this reflects vested interests and has undermined the viability of bachelor's level programs (Wardle et al., 2012). These impacts are discussed further in **Chapter 6**.

Finally, this review confirms earlier findings from the Lin Report that while naturopaths and herbalists report membership of multiple professional associations whose policies vary with respect to statutory registration for the profession, a majority of naturopaths continue to report they support statutory registration for the profession.

In 2005, more than half of naturopaths were found to be members of two or more professional associations, with numerous associations offering membership for naturopaths (Lin et al., 2005: 164). In this study, naturopaths report concerns about unqualified persons co-opting the title of 'naturopath' without adequate training and a majority continue to support statutory registration (Braun et al., 2013; Steel et al., 2020c). Fragmentation of representative arrangements dilutes the ability of associations to set and enforce practice and education standards (Wardle et al., 2012; Wardle et al., 2013).

5.5 CONCLUSIONS

Naturopaths and herbalists in Australia have a broad scope of practice, providing primary care to diverse populations with diverse health needs. They treat patients with a variety of health conditions, using ingestive medicines such as herbal medicines. The majority of naturopaths and herbalists are female and aged under 60 years. They work principally in solo private practice where, compared with group and multi-disciplinary practices, systems of clinical governance are likely to be weak or non-existent.

While naturopathy is a multi-modality practice employing an eclectic range of practices, naturopaths frequently prescribe ingestive medicines in their practice, most commonly herbal medicines and nutritional supplements.

It is imperative that naturopaths and herbalists are properly trained to work as primary care practitioners. Degree level training is considered by a majority of the profession to be the minimum qualification required for safe and competent practice of the naturopathy & WHM professions and degree programs have been available in Australia for over 20 years. However, the qualifications profile of the naturopathy/WHM workforce has changed since 2005, with a greater proportion of the profession with diploma level qualifications rather than degree level. This is not surprising given two factors: the lack of a mechanism for enforcing degree level as the minimum qualification for entry to practice and the fragmented nature of representative arrangements, with some professional associations continuing to accept less than degree level qualifications for membership.

6
EDUCATION OF NATUROPATHS & HERBALISTS FOR ENTRY TO PRACTICE

Jenny Carè & Anne-Louise Carlton

6.1 INTRODUCTION

In 2005, the Lin Report presented the results of a 2003 survey of education providers that gave a comprehensive picture of the arrangements for educating naturopaths and herbalists for entry to practice in Australia.

The purpose of this chapter is to present the results of a further survey of Australian naturopathy and WHM education providers, undertaken in June-July 2021. The chapter presents a profile of education providers and the programs of study available for entry to practice and postgraduate studies in naturopathy and WHM. Key changes in the sector since 2005 are discussed, along with issues confronting the profession with respect to education.

6.2 THE LIN REPORT ON NATUROPATHIC EDUCATION

The Lin Report (2005) provided a brief history of arrangements for educating naturopaths and herbalists for entry to practice – see Textbox 6.1.

Textbox 6.1: History of education of naturopaths and herbalists for entry to practice

The development of tertiary education for naturopaths and herbalists in Australia has been marked by periods of growth, instability and diversity.

Education of naturopaths in the early twentieth century was principally via self-teaching or apprenticeship. Early growth in the number of private training colleges offering certificate and diploma courses was slow but accelerated from the 1980s on (2005: 118). By the late 1990s, vocational education and training (VET) sector accredited diploma and advanced diploma courses were being delivered via registered training organisations (RTOs) under the Australian Health Training Package. The first bachelor's degree course in naturopathy commenced in 1995 at Southern Cross University (SCU).

By the early 2000s, bachelor's degrees were available at both public and private sector educational institutions, accredited by the responsible state government offices of higher education, while VET sector accredited qualifications and non-accredited short courses continued to be offered

Source: Lin et al., 2005: 118

When Lin & colleagues reported their findings 20 years ago, education arrangements for the professions of naturopathy and WHM were complex, with diverse offerings at public and private education institutions and from certificate through to bachelor's degree. While naturopaths and herbalists were considered primary contact healthcare professionals, the education standards for entry to practice qualifications varied. Lin & colleagues concluded that:

- training programs at the lower end of the scale were unlikely to adequately prepare graduates for practice, and
- given the degree of risk in naturopathic practice and the need for better integration of complementary care with mainstream care, education to at least bachelor's degree was required (2005: 154).

- The Lin Report recommended the profession work towards a bachelor's degree as the minimum requirement for entry to practice and that courses be subject to external accreditation in accordance with independent standards embedded in an effective system of regulation (2005: 154).

6.3 METHODOLOGY

The objectives of this survey were similar to those of the Lin report education survey – to provide a comprehensive picture of the arrangements for training of naturopaths and herbalists for clinical practice in Australia and the educational opportunities available to these practitioners for postgraduate training.

Qualtrics Survey Software was used to develop a survey tool. The questions were based on the original Lin Report survey instrument but were updated and adapted to enable online completion. The draft tool was piloted by the education provider members of the ANC.[32]

Ethics approval was obtained from the Southern Cross University's Human Research Ethics Committee.

Textbox 6.2 lists the steps taken to identify naturopathy tertiary education providers.

Five education providers were found that met the criteria. These providers were sent an invitation to participate via email, along with a link to access the survey tool. Also included was an information sheet and a consent form.

The survey was distributed in the first week of June 2021. Two education providers had not responded by the due date (end of July 2021) and were notified of an extension until September 2021. Where an education provider did not respond to the survey, data were drawn from publicly available information on the provider's website.

Information provided in the completed surveys was also supplemented by a search of publicly available information from provider websites. Missing information and unclear responses to survey questions were clarified by contacting the education provider directly.

Textbox 6.2: Steps in process to identify naturopathy tertiary education providers

1. The government training website was searched for the names of each education provider identified in the Lin Report.
2. If the provider was listed on this website, its website was searched, to identify whether the provider was continuing to offer a naturopathic or WHM qualification.
3. A search was performed using the web addressed listed on the RTO website to determine if the provider was trading as a non-RTO.
4. If not found, then the following website was searched for the provider https://www.teqsa.gov.au/national-register.
5. If the provider was not listed on training.gov.au then an Ecosia search was performed to locate a digital profile of the organisation (for example, a direct website or a directory listing).
6. If a website was found, then it was searched for naturopathic and WHM qualifications and the table updated accordingly.
7. Finally, a general Ecosia search was carried out to locate any additional providers, using the following terms:
   - Studying naturopathy
   - Studying western herbal medicine
   - Studying herbs
   - Training as a naturopath
   - Training as a herbalist
   - Training as a western herbalist
   - I want to study to be a naturopath
   - I want to study to be a western herbalist
   - I want to study to be a herbalist

32 For a link to survey tool see ANC website.

6.4 EDUCATION PROVIDERS AND AWARDS

Number and type of education providers

The Australian tertiary education sector includes public and private universities, Australian branches of overseas universities, university colleges, and institutes of higher education. Tertiary education providers offer qualifications ranging from undergraduate awards (from AQF 5 diplomas to AQF 7 bachelor's degrees) to postgraduate awards (graduate certificates and diplomas, master's and doctoral degrees).

In 2003, 43 education providers were identified of which 30 responded to the survey. In 2021, despite exhaustive searches, only five education providers were identified. Since 2005, some providers have changed names and provider arrangements, one new provider has entered the market, and two universities (Southern Cross and Western Sydney) closed down their naturopathy degree programs, with Southern Cross relaunching programs several years later.

The five providers identified are:

- Endeavour College of Natural Health
- Nature Care College
- Southern Cross University
- Switch on Health
- Torrens Uni**ver**sity Australia

The remaining providers from the 2003 list could not be found and it is assumed they are no longer operating. The College of Somatic Studies was found listed on the training.gov.au website but no further details could be located, and web links were broken.

Three providers responded to the survey invitation: Southern Cross University, Switch on Health, and Torrens University Australia, reflecting a 60% response rate. Publicly available information on the remaining providers, Endeavour College of Natural Health and Nature Care College, was gathered from their websites.

Appendix 6.1 lists the education providers located in 2003 compared with the current survey. In 2003, 43 education providers were offering 104 undergraduate and postgraduate awards. Of the 43 providers, eleven were in the university sector, 32 were private colleges and four were TAFE colleges (Lin et al., 2005: 120). Eighty-six per cent of programs were at the undergraduate level and 14% were postgraduate programs (Lin et al., 2005: 120). In survey responses, online programs were offered at eight campuses for part of the undergraduate program. Two providers offered fully online advanced diploma programs in naturopathy and WHM (Lin et al., 2005: 127).

By 2021, a marked reduction in the number of education providers is evident, with just five education providers offering naturopathy and WHM programs at eleven campuses across seven cities.

Table 6.1 lists the education providers and programs provided.

Table 6.1: Naturopathy and WHM education providers and programs

Education provider	Registered with TEQSA/ ASQA	Program	Naturopathy	WHM	Total	Program TEQSA accredited or University accredited
Undergraduate programs						
Nature Care College	NO	Advanced diploma	1	1	2	NO
Switch on Health	NO		1	1	2	NO
Endeavour College of Natural Health	YES	Bachelor's degree	1		1	YES
Torrens University Australia	YES		1	1	2	YES
Postgraduate programs						
Southern Cross University	YES	Graduate certificate	1		1	YES
Southern Cross University	YES	Master's degree	1		1	YES
		Total	6	3	9	

Of the five education providers, two are universities (one public and one private) and three are private education providers:

- Australian College of Natural Medicine Pty Ltd, trading as Endeavour College of Natural Health was established in 1975 and is a company limited by shares.[33]
- Nature Care College Pty Ltd was established in 1973 and is a private company.[34]
- Southern Cross University was established in 1994 is a body corporate established under NSW legislation.[35,36]
- Switch on Health was established in 2019 and advised it is a corporation under the Corporations Act.[37]
- Torrens University Australia was established in 2014 and is a private university established under an SA Act of Parliament.[38]

Details of the governance arrangements for Endeavour College of Natural Health, Southern Cross University and Torrens University Australia are accessible on their respective websites.[39] Little information is publicly available on the websites of Nature Care College or Switch on Health about their governance arrangements.

As in 2003, the majority of campuses were located in the eastern states. Endeavour College of Natural Health offers a degree program at six campus locations (Adelaide, Brisbane, Gold Coast, Melbourne, Perth, and Sydney) while Torrens University offers degree programs at three campuses (Brisbane, Melbourne and Sydney).

Endeavour College of Natural Health and Torrens University Australia are on-campus programs. Endeavour College of Natural Health delivers theory subjects via mixed mode, a combination of online, livestream, blended, and on-campus study modes. Torrens University advised that it offers blended learning mode, including in-person and online modes, using flipped learning delivery. Both education providers advised they require practical and clinical learning to be conducted in-person at the educator-provided student-led teaching clinics.

Nature Care College delivers programs in real time via a 'virtual classroom' and/or students can view the live recording at any time during the College term. Switch on Health advised it offers programs online.

Southern Cross University offers a master's degree and nested graduate certificate (non-clinical), a fully online program provided as an upskilling pathway for students who already hold a qualification in naturopathy.

Accreditation and quality assurance

Good practice requires programs to be designed with input from professional associations and accredited by an independent education authority – to ensure education standards are maintained (Lin et al., 2005: 128). This section sets out arrangements for accreditation of education programs and providers, both government and industry accreditation.

Government education accreditation agencies

Tertiary Education Quality and Standards Agency (TEQSA)

TEQSA is the national regulator of higher education in Australia, an independent agency established under the *Tertiary Education Quality and Standards Agency Act 2011* (TEQSA Act). TEQSA has statutory responsibilities under the Act to:

- register regulated entities as higher education providers and accredit their programs of study
- conduct compliance and quality assessments
- conduct re-accreditation assessments of programs developed by providers without self-accrediting authority
- provide advice and make recommendations to the Federal Minister responsible for Education on matters relating to the quality and regulation of higher education providers
- cooperate with similar agencies in other countries
- collect, analyse, interpret and disseminate information relating to quality assurance practice and quality improvement in higher education
- investigate and take action against individuals or organisations offering or advertising commercial academic cheating services to students at Australian higher education providers.

TEQSA administers a compliance framework that applies to all registered higher education providers and accredited programs. All providers are expected to comply with the TEQSA *Higher Education Standards Framework (Threshold Standards) 2021* to manage their higher education activities and risks. This includes for matters such as the adequacy of facilities, staffing levels, support services, and academic and corporate governance.

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33 Endeavour College (Business name: Australian College of Natural Medicine Pty Ltd (ABN: 57 061 868 264) is an Australian Proprietary Company, limited by shares with the Australian Securities and Investments Commission (ASIC), and by the company's Articles of Association.
34 Nature Care College (Business name: Nature Care College Pty Ltd (ABN: 77 105 282 264) is an Australia Propriety Company, limited by shares with the Australian Securities and Investments Commission (ASIC).
35 See Southern Cross University Act 1993.
36 Southern Cross University offered the first degree course in naturopathy in 1995 (Lin et al, 2005: 118) and continued to do so until 2017 when SCU ceased offering this course.
37 See Switch On Health.
38 See Torrens University Australia.
39 See Endeavour College Governance, Southern Cross University Governance and Torrens University Australian Governance.

The TEQSA website provides information on the accreditation standards and processes that apply to registered higher education providers.[40]

Australian Skills Quality Agency (ASQA)

ASQA regulates training providers that deliver vocational education and training (VET) qualifications and programs to students in Australia or offer Australian qualifications overseas. ASQA accredits VET programs to ensure they meet nationally approved standards, based on industry, enterprise, education, legislative, and community needs. ASQA also has an interest in ensuring prospective students of programs that are not delivered by registered training providers, receive relevant information from education providers regarding the status of programs and what prospective students will be eligible for if they enrol in non-government accredited training programs. This includes which professional associations the student may or may not be eligible to join and which product suppliers will accept their qualifications to establish a trading account and gain access to practitioner only products.

Training.gov.au is the official national register of information on VET in Australia. The national register has the details of all nationally recognised training products, including accredited programs, endorsed training package qualifications, units of competency, and skill sets. It also has a searchable database of providers registered to deliver nationally recognised training.

Training packages specify the knowledge and skills required by individuals to perform effectively in the workplace, expressed in units of competency. Training packages also detail how units of competency can be packaged into nationally recognised and portable qualifications that comply with the Australian Qualifications Framework (AQF). Training packages are used for a range of purposes, but predominantly:

- by training providers, to design training curriculum tailored to support individual learner needs, and the needs of employers and industry
- by employers, to assist with workforce design, development, and structure

Registered training providers can only deliver training package qualifications and units of competency if those products are in their scope of registration.

Government accreditation

In 2003, most programs were independently accredited by government authorities, either by vocational education authorities, an office of higher education, or by a university. However, some providers reported that their programs were recognised by a professional association and not by an education authority (Lin et al., 2005: 128).

In 2021, three providers are registered as higher education providers under the TEQSA Act & are required to comply with the *Higher Education Standards Framework (Threshold Standards) 2021*. The naturopathy bachelor's degree program offered by Endeavour College of Natural Health is accredited by TEQSA while as universities, Southern Cross University & Torrens University Australia are authorised by TEQSA to self-accredit their own programs via an Academic Board.

Two providers – Nature Care College and Switch on Health – are not registered tertiary education providers and their programs are not accredited by TEQSA or any state government tertiary education authority. These providers are also not registered with the ASQA as a registered training organisation and their programs are not accredited advanced diplomas under the Health Training Package.

Nature Care College provides a disclaimer on the final page of its program prospectus which states:

> ***This course is not a nationally recognised qualification under the Australian Qualification Framework and does not lead to the issuance of AQF documentation. For course accreditation details please refer to the Course Recognition Information*** (Nature Care College 2023: 9).

Switch on Health also provide a disclaimer on their website that states:

> ***The Advanced Diploma of Naturopathic Practice is not a nationally recognised qualification under the Australian Qualification Framework. It does not lead to issuance of AQF documentation such as a Statement of Attainment. It is however recognised by the Australian Traditional-Medicine Society who are the largest professional association representing natural therapies in Australia, and the only natural medicine practitioner association appointed to two Commonwealth statutory committees. Switch on Health is not a Registered Training Organisation (RTO). To read more about how this improves the quality of our qualifications, and produces better outcomes for you as a student and practitioner, please click here. See Switch on Health.***

Professional association accreditation or recognition

Chapter 7 Table 7.7 presents information about the accreditation or recognition of education programs undertaken by professional associations that represent naturopaths. Graduates of an accredited or recognised program generally qualify for practitioner membership of the association without having to sit an examination or other assessment but are required to present evidence including their certified qualification, current first aid, and public liability/professional indemnity insurance.

Four organisations (ARONAH, ANTA, ATMS and NHAA) have published accreditation standards against which qualifications may be assessed for recognition of graduates. As a registering body, the objective of

40 See TEQSA course accreditation.

ARONAH is to undertake accreditation of education programs on behalf of all professional associations. However, in the current environment, education providers seek accreditation of their programs through any or all of the organisations that graduates may seek to join upon graduation.

While all organisations (ANTA, ANPA, ARONAH, ATMS, CMA and NHAA) publish a list of accredited programs for membership purposes, only two (ARONAH & NHAA) publish a detailed description of the accreditation process including fees charged. The ANTA website indicates that no fees are charged for accrediting programs. ARONAH's Naturopathic Education Accreditation Standards appear to be the most extensive set of standards, published in 2021 following a process of public and stakeholder consultation.

Table 6.2 lists the education programs that are accredited or recognised by one or more professional bodies for membership purposes and via other quality assurance mechanisms, such as academic boards and industry or program advisory or consultative committees.

TABLE 6.2: Accreditation/recognition status of education programs by provider

Quality assurance mechanism	Endeavour College of Natural Health	Torrens University Australia	Southern Cross University	Switch on Health	Nature Care College
Registered tertiary education provider	✓	✓	✓	✗	✗
VET registered training organisation	✗	✓[41]	✗	✗	✗
ANPA	✓	✓	✓	✗	✗
ANTA	✓	✓	✓	✗	✗
ARONAH	✗	✗	✓	✗	✗
ATMS	✓	✓	✓	✓	✓
CMA	✓	✓	✓	✗	✗
NHAA	✓	✓	✓	✗	✗
Academic Board	✓	✓	✓	✗	No information
Industry/program advisory committee	✓	✓	✓	✗	No information

Internal quality assurance mechanisms

In 2003, the vast majority of education providers (93%) indicated that course advisory committees were predominantly comprised of academics and teaching staff. Private providers were more likely to include administrative staff and community practitioners, and universities were more likely to include professional association representation.

In 2021, higher education providers are expected to have a range of internal quality assurance mechanisms in place in accordance with requirements set by TEQSA.

Three education providers publish or provided details of their internal quality assurance mechanisms:

- The website of Endeavour College of Natural Health shows an Academic Council that is made up of internal and external academics, community/professional representation, student/alumni representation, and senior staff.
- Torrens University advised its Course Advisory Committee meetings are held yearly. Members are from industry, professional associations, external academics, alumni, current students, and internal University course stakeholders. Continuous course improvements are managed by the University Learning and Teaching Committee with major changes required to have Academic Board approval.
- Southern Cross University advised it has a course advisory committee for naturopathy that meets annually, and that its courses are reported on annually and reviewed every three years by academic staff in the Academic Portfolio Office, Faculty of Health Board, Accreditation Committee, and Academic Board academic and administrative staff.

No information was found on the Nature Care College website or in the course prospectus regarding academic governance and review arrangements.

Switch on Health reported that it does not have an academic board and that external reviews are conducted by the accrediting professional association, the ATMS.

41 Torrens University Australia is dual sector accredited and accredits VET courses. However there are no VET courses accredited by Torrens University Australia related to naturopathy or WHM.

Removal of naturopathy & WHM training programs from the Health Training Package

In 2012, the Community Services and Health Industry Skills Council (CS&HISC) undertook a review of all complementary and alternative health qualifications in the Health Training Package (HLT07), including naturopathy and WHM, with the dual aims of better meeting industry needs and complying with the new national *Standards for Training Packages*.

In September 2013 and February 2014, the CS&HISC invited stakeholder submissions. Following this process, the CS&HISC announced in July 2014 that it found the work of naturopaths and herbalists aligns with bachelor's level qualifications, that this level of training is needed to meet professional outcomes, and there was a majority support for transition to bachelor's level qualifications.

In accordance with this finding, the CS&HISC announced that by December 2015, naturopathy and WHM qualifications would be removed from the HLT07. While ATMS made representations opposing this proposal (letter dated 30th August 2014, ATMS 2014) the decision was implemented by CS&HISC.

Following further representations from ATMS on this issue, in 2019 a recommendation to reinstate naturopathy and WHM advanced diploma qualifications in the Health Training Package was published in the *Complementary Health Industry Reference Committee Skills Forecast*. However, it is understood this proposal was opposed by other naturopathy/WHM professional associations, and the recommendation has not, to date, been implemented. The ATMS has since advised that it is 'qualification agnostic' and continues to recognise unaccredited naturopathy advanced diploma programs for membership purposes (ATMS 2022).[42]

Affiliations with other education providers

In 2005, Lin & colleagues report approximately half of provider sites had affiliations with other education providers in Australia, and twelve had overseas affiliations (2005: 122). Affiliations within the Australian context were arranged mostly to direct diplomates to universities as part of bachelor's degree conversion programs, and as pathways to higher education and research.

In 2021, Southern Cross University, Torrens University, and Endeavour College of Natural Health all reported educational affiliations. Southern Cross University is affiliated with Regional Universities network (RUN), Endeavour College of Natural Health advised of an affiliation with Independent Higher Education Australia.[43] Torrens University Australia advised of affiliations with THINK Education, part of Torrens Global Education Services,[44] the Universidade Anhembi Morumbi in Brazil and Strayer and Capella Universities in the USA.

Torrens University Australia, Endeavour College of Natural Health, and Southern Cross University's National Centre for Naturopathic Medicine all hold Educational Membership of the World Naturopathic Federation.[45]

6.5 PROGRAM DESIGN AND CONTENT

Undergraduate programs

In 2003, the majority of naturopathy/WHM programs were vocational, with 54% of programs offered at the advanced diploma level (AQF 6), another 9% were diploma programs (AQF 5), and a further 7% were certificate level programs (AQF 4 and below). Bachelor's degrees (AQF 7) comprised 16% of program offerings of which 11 programs were in naturopathy, one in WHM, and five were conversion programs for diplomates. Program duration for advanced diplomas ranged from two to four and a half years, with most offered over three years. Bachelor's degree programs ranged from three to five years, with most offered over four years full-time (Lin et al., 2005: 126).

Table 6.3 provides details of the undergraduate programs currently available. Currently four providers offer undergraduate programs in naturopathy and/or WHM:

- Endeavour College of Natural Health has a Bachelor of Health Science (Naturopathy)
- Torrens University has Bachelor of Health Science degrees in both naturopathy and WHM
- Nature Care College offers advanced diplomas of clinical naturopathy and clinical WHM that are not government accredited VET programs
- Switch on Health provides advanced diplomas of naturopathic practice and Western herbal practice that are not government accredited VET programs.

Torrens University launched Naturopathy/WHM programs in 2020 while its founding college, Southern School of Natural Therapies (SSNT), has offered naturopathy and WHM programs since 1961.[46] Endeavour College of Natural Health and its predecessors have been offering naturopathy/WHM programs since 1975. Switch on Health established two programs, in naturopathy and WHM, in 2019. No information could be found on when Nature Care College established its two programs although according to their website the College has been training naturopaths and herbalists since 1973.

All undergraduate programs may be completed full-time or part-time:

- Endeavour College of Natural Health delivers a its naturopathy degree over four years full-time with subjects delivered in two semesters a year. Part-time study is generally twice the full-time duration.
- Torrens University Australia delivers subjects over three trimesters a year, the WHM degree is a 3-year program when completed full-time and the Naturopathy degree is a 4-year degree when completed full-time.

42 See ATMS website: https://www.atms.com.au/colleges-courses/
43 Independent Higher Education Australia is a peak body representing Independent Higher Education providers in Australia.
44 Think Education is a higher education and vocational education and training provider in Australia.
45 See WNF Educational Membership.
46 See Torrens University website, celebrating 60 years of SSNT.

- Nature Care College advises in its prospectus that the academic year has three terms of 12 weeks duration with a 3.5-year study plan for naturopathy and a 3- or 4-year study plan for clinical WHM.
- Switch on Health advised its programs may be completed over 4.5 years full-time, or ten years part-time, with each subject to be completed within a six-month period.

Contact hours

In 2003, there was variation in the total contact hours reported by providers of undergraduate programs. Naturopathy advanced diplomas ranged from 1240 to 4018 hours (mean = 2314), while naturopathy degrees ranged from 1492 to 3220 hours (mean = 2216). WHM advanced diplomas ranged from 1274 to 3060 hours (mean = 1837), and the one WHM degree was 1550 hours (Lin et al., 2005: 123).

In 2021, rather than contact hours, the AQF refers to 'volume of learning', defined as 'the notional duration of all activities required for the achievement of the learning outcomes specified for a particular AQF qualification type. It is expressed in equivalent full-time years.'[47] Volume of learning includes all teaching, learning and assessment activities such as guided learning (classes, lectures, tutorials, online, or self-paced study), individual study, research, learning activities in the workplace, and assessment activities. The generally accepted length of a full-time year for educational participation is 1200 hours.

Total program contact hours varied between undergraduate programs. While we have reported the data supplied by survey respondents (see **Table 6.4**), with the shift of emphasis in tertiary education to measurement of volume of learning and the variety of delivery modes, contact hours as a means of comparison of programs has less utility than it once did. The trend towards more flexible modes of delivery accelerated during the COVID-19 pandemic (Carlton et al., 2024; Leslie et al., 2023).

Endeavour College of Natural Health advised of a total of 4755 hours inclusive of student self-study hours for its naturopathy degree.

Torrens University reported 4300 total hours inclusive of student self-study hours. The Torrens University herbal medicine degree reported a total of 3340 hours inclusive of student self-study hours.

The total weekly contact hours for full-time students enrolled in the three undergraduate bachelor's degree programs was between 24 to 30 hours. Additional weekly attendance hours or weekend intensive face-to-face sessions for practical and clinical training are required throughout the study duration.

Nature Care College details in the program prospectus a weekly study load of approximately 10 to 12 class hours with an equivalent number of student self-study hours for clinical naturopathy and approximately 8 class hours with an equivalent number of student self-study hours for clinical WHM. This equates to an estimated 3170 hours for the clinical naturopathy advanced diploma and approximately 1930 for the clinical WHM advanced diploma, both of which are inclusive of student self-study hours.

Switch on Health reported a total of 2520 study hours for the naturopathy advanced diploma and 1570 study hours for the Western herbal practice advanced diploma. As these are offered entirely online there are no prescribed contact hours, but guidance provided to full-time students in the program brochure recommends an average of fifteen hours per week for the naturopathy program and nine hours study time per week for Western herbal practice.

Endeavour College of Natural Health and Torrens University advised that they exceed the AQF requirement of 1200 hours volume of learning per full-time year for their programs. The Nature Care College and Switch on Health programs do not meet the AQF benchmark for volume of learning.

Biomedical and social sciences

In 2003, biomedical and social sciences such as anatomy, physiology, chemistry, pathophysiology, psychology, and clinical diagnosis featured in most programs. However there was wide variation of contact hours for the sciences, from 300 to 840 hours for naturopathy advanced diplomas, and 507 to 923 for WHM advanced diplomas (Lin et al., 2005: 123). For bachelor's degrees, hours devoted to the sciences ranged from 416 to 930 hours for naturopathy and 815 hours for WHM (Lin et al., 2005: 123). Research modules featured in around half of the advanced diploma programs, and in all but one of the university programs (Lin et al., 2005: 125).

In 2021, providers reported that all undergraduate programs included a range of biomedical bioscience subjects such as anatomy, physiology, chemistry, biochemistry, pathophysiology, pharmacology, counselling, and/or psychology. Endeavour College of Natural Health and Torrens University Australia reported they include additional nutritional biochemistry and research subjects. These providers reported a focus on evidence-based practice throughout the degrees with scaffolded learning allowing students to achieve skills to critically review scientific literature.

The Endeavour College of Natural Health website indicated its core subjects include foundations of public health and sociology of food. Torrens University reported it offers a range of elective subjects from a variety of related disciplines of public health, counselling, and functional nutrition. Reported program hours for the sciences range from 918 hours to 1320 hours for the two naturopathy degrees, and 1080 hours for the WHM degree.

47 See AQF guideline on volume of learning.

Switch on Health reported 520 hours of biomedicine and social sciences subjects for both awards (see Table 6.3).

Naturopathy and WHM theory

The mix of core and elective theory subjects delivered in programs of 2021 is similar in content to those described in the Lin Report (Lin et al., 2005: 123-4). In 2005 theory subjects included history and philosophy of naturopathy, nutrition, herbal medicine, naturopathic health assessment, naturopathic clinical medicine, ethical and legal studies, communication and counselling, and practice management (Lin et al., 2005: 123). Similar subjects were offered in WHM programs, although there was greater emphasis on herbal medicine and pharmacognosy, and less emphasis on nutrition subjects (Lin et al., 2005: 124).

In 2021, programs in naturopathy and WHM theory subjects appear broadly consistent in their core offerings across the providers (see Table 6.3). Subjects include:

- naturopathic philosophy
- nutrition
- herbal medicine
- herbal botany and manufacturing
- herbal pharmacology
- naturopathic case taking and assessment
- nutritional and herbal therapeutics

However, programs delivered at bachelor's degree AQF7 require more advanced skills in critical thinking, decision-making, and independent practice skills compared to advanced diplomas. The programs offered by Nature Care College and Switch on Health described as 'Advanced Diplomas' are not government accredited (and therefore not benchmarked to AQF 6 level) and are unlikely to deliver the higher learning outcomes of an AQF7 accredited qualification.

Nature Care College offers homeopathy as a core subject in its clinical naturopathy advanced diploma and Switch on Health offers homeopathy as a core subject in the two advanced diploma programs. Endeavour College of Natural Health and Torrens University both offer homeopathy as an elective subject. Flower essences is offered by all four undergraduate providers, either as core or elective subjects and aromatherapy is offered by Switch on Health as a core subject. Iridology is offered by all providers, as a core subject by Nature Care College and Switch on Health, as an elective by Torrens University, and as part of various subjects throughout the curriculum offered by Endeavour College of Natural Health.

Switch on Health advised it also includes introductory subjects in Ayurveda and traditional Chinese medicine in both of its programs.

Clinical training and work integrated learning

In 2003, the majority of bachelor's degree programs in naturopathy included 400-600 clinical teaching hours, and the majority of advanced diploma programs had a range between 200 and 272 clinical hours (Lin et al., 2005: 125). These hours were reportedly the number of hours spent in a clinic, rather than the number and types of patients or cases managed by students. Concern was expressed in the report regarding the limited number of clinical hours in many programs and the authors called for greater research in this area of teaching practice (Lin et al., 2005: 125).

In 2021, bachelor's degree (AQF 7) programs were expected to deliver learning outcomes rather than a specified number of hours of clinical training. Clinic teaching hours across the programs tended towards greater variation compared with theory subjects. Hours for clinic teaching in naturopathy qualifications ranged from 250 to 640 hours, while equivalent teaching for herbal medicine programs showed variation ranging from 250 to 560 hours (see Table 6.3). Clinic subjects include:

- clinical case taking and analysis
- clinical examination
- clinical diagnostics and assessment
- functional laboratory testing
- treatment plans
- referral plans

Clinical training at AQF7 level is expected to include case analysis, risk management, collaborative and integrative practice. Some programs also address social justice and human rights, global health issues, and advocacy.

Endeavour College of Natural Health and Torrens University Australia operate student clinics for practicum training during which students treat general public clients and are overseen by clinic supervisors. The Endeavour College of Natural Health clinical training program of 1152 hours includes simulated clinical practice, pre-clinical, clinical practicum, and elective clinic of timetable contact hours. Torrens University Australia reported its clinical training program includes work integrated learning, simulated clinical practice, and direct clinical placement. It runs from year 2 to year 4, incorporating 640 training hours comprised of pre-clinical and in-clinical classes (simulated clinic), work integrated learning, and clinical practice. The Torrens University Australia WHM degree has a similar format to the BHSc (Naturopathy) degree and requires completion of 568 hours during years 2 and 3.

Nature Care College details in their program prospectus that 400 hours of clinical practice training is required for naturopathy and 200 hours of clinical practice training is required for WHM. For both advanced diplomas, 50% the clinical practice training must be conducted live in the College's online virtual wellness centre under College

clinical training practitioners and 50% must be completed externally under the supervision of an approved qualified practitioner/s in their clinical practice.

Switch on Health reported it does not operate a student clinic. It advised that students are required to complete 400 hours of clinic for naturopathy and 200 hours for herbal medicine of which up to 50% may be completed online (telehealth). A program coordinator maintains a network of practitioners to supervise student clinic hours or students may nominate their own supervisor. Minimum requirements for acceptance of practitioners as supervisors include that they hold qualifications and practise in the discipline, have at least three years full-time experience, and are a member of a relevant professional association.

Table 6.3: Summary of undergraduate and postgraduate programs and total teaching hours by curriculum area

Institution	Program	Program hours	Naturopathy/WHM modality subjects	Hours	Naturopathy/WHM clinical subjects hours associated with clinic	Hours	Biomedical & social science subjects WNF mapping % on biological sciences etc	Hours
Undergraduate programs								
Endeavour College of Natural Health	Bachelor of Health Science (Naturopathy)	4755 inclusive of self-study hours	History of healing, naturopathic philosophy, principles and practice, nutrition, herbal botany and manufacturing, herbal medicine, medicinal food science, herbal medicine, advanced herbal medicine, pharmacology and pharmacognosy, flower essences, dietary planning across the lifespan, establish and manage a practice; plus one stream elective of four subjects from three streams offered in homeopathy, wellness, and nutrition, weight management, and one free choice elective from: wellness practice, homeopathic clinical practicum, food, nutrition, weight management, and mindfulness.	1725 inclusive of self-study hours	Clinical skills, clinical herbal medicine, clinical diagnostic techniques, clinical examination, clinical nutritional medicine, naturopathic clinical practicum. Clinic practicum.	900 inclusive of self-study hours 731 inclusive of self-study hours	Human biological science, chemistry, biochemistry, nutritional biochemistry, pathology and clinical science, pharmacology, pathology and clinical science, communication and counselling, critical enquiry, psychology and counselling theory, interpersonal skills of the helper, foundations of public health, sociology of food, nutritional physiology research.	1350 inclusive of self-study hours
Nature Care College	Advanced Diploma of Clinical Naturopathy	3170 Inclusive of self-study hours	Nutrition, principles of micronutrients, nutritional therapeutics, herbal medicine, herbal therapeutics, homoeopathy, botany, medicinal weeds, herbal manufacturing, Bach flower remedies, iridology, introduction to natural medicine.	1150	Symptomatology, diagnosis, pathology, naturopathic diagnosis, clinical assessment, clinical case studies, evidence-based practice, clinical practice training. Clinical practicum.	950 400	Anatomy & physiology, body chemistry, communication, professional expertise, business practice, safe practices, pharmacology.	670
Nature Care College	Advanced Diploma of Clinical Western Herbal Medicine	1930 Inclusive of self-study hours	Herbal medicine, herbal therapeutics, botany, medicinal weeds, herbal manufacturing, introduction to natural medicine.		Symptomatology, diagnosis, pathology, naturopathic diagnosis, clinical assessment, clinical case studies, evidence-based practice, clinical practice training. Clinical practicum.	530 200	Anatomy & physiology, body chemistry, communication, professional expertise, business practice, safe practices, pharmacology.	500
Switch on Health	Advanced Diploma of Naturopathic Practice	2520 Self-study hours	Nutrition, herbal medicine, homoeopathy, naturopathic nutrition, herbal medicine - materia medica, homoeopathic principles, homoeopathic first aid, natural health philosophy, homoeopathy: case taking, repertorising, and materia medica, homoeopathy materia medica and acute prescribing, flower essences, iridology, introduction to aromatherapy, traditional Chinese medicine, and ayurveda, herbal pharmacology, herb botany and manufacturing, nutrition therapeutics, herbal medicine therapeutics, nutritional special topics, herbal medicine special topics.	1350	Case taking, lab tests, and investigations, symptomatology, diagnosis (includes 400 clinic hours including minimum 90 hours of homoeopathy – off-campus, non-faculty practitioners). Clinical practicum.	250 400	Anatomy & physiology, chemistry, biochemistry, microbiology, pathology, safe practices, counselling, professional practice, pharmacology.	520

Institution	Program	Program hours	Naturopathy/WHM modality subjects	Hours	Naturopathy/WHM clinical subjects hours associated with clinic	Hours	Biomedical & social science subjects WNF mapping % on biological sciences etc	Hours
Switch on Health	Advanced Diploma of Western Herbal Practice	1570 Self-study hours	Introduction to herbal medicine, herbal medicine – materia medica, natural health philosophy, flower essences, iridology, introduction to aromatherapy, traditional Chinese medicine, Ayurveda, herbal pharmacology, botany and manufacturing, herbal therapeutics, herbal medicine special topics.	600	Case taking, lab tests, and investigations. Clinical practicum.	250 200	Anatomy & physiology, chemistry, biochemistry, microbiology, pathology, safe practices, counselling, professional practice, pharmacology.	600
Torrens University Australia	Bachelor of Health Science (Naturopathy)	4300 Inclusive of self-study hours	Complementary medicine foundations, human nutrition, botany & herbal manufacturing, herbal materia medica, herbal pharmacology, herbal therapeutics, nutritional therapeutics, lifespan nutrition, advanced herbal therapeutics, entrepreneurship, professionalism & business skills in health; plus two specified electives from: dietary counselling & planning, functional nutritional medicine, mediation and conflict management, foundations of public health, iridology, homeopathic foundations, applied homeopathy, flower essences and one unspecified elective from the TUA subject suite.	2040	Clinical studies, clinical assessment. Work Integrated Learning, Simulated clinic, Clinical Placement.	420 640	Biological foundations, human structure & physiology, human systems & pathophysiology, human biochemistry, nutritional biochemistry & human metabolism, integrated pharmacology, evidence-based practice, critical literature review.	1200
Torrens University Australia	Bachelor of Health Science (Western herbal medicine)	3340 Inclusive of self-study hours	Complementary medicine foundations, human nutrition, botany & herbal manufacturing, herbal materia medica, herbal pharmacology, herbal therapeutics, advanced herbal therapeutics, entrepreneurship, professionalism & business skills in health; plus one specified elective from: mediation and conflict management, flower essences, iridology, food as medicine, critical literature review and one unspecified elective from the TUA subject suite.	1560	Clinical studies, clinical assessment. Work Integrated Learning, Simulated clinic, Clinical Placement.	252 568	Biological foundations, human structure & physiology, human systems & pathophysiology, human biochemistry, integrated pharmacology, evidence-based practice.	960
Southern Cross University	Graduate Certificate in Advanced Naturopathic Medicine	600	Critical perspectives in naturopathic philosophy; plus two electives from: cognition and the healthy brain, integrative mental health, integrative gastroenterology, gut microbiome and health, food as medicine, integrative women's health, integrative reproductive health	450	Practice-based health research	150		
	Master of Advanced Naturopathic Medicine	1200	Critical perspectives in naturopathic philosophy; plus three electives from: cognition and the healthy brain, integrative mental health, integrative gastroenterology, gut microbiome and health, food as medicine, integrative women's health, integrative reproductive health	750	Practice-based health research. Health research project AHealth research project B. Evidence translation and implementation	450		

Postgraduate programs

In 2003 there was a small but growing presence of postgraduate education in naturopathy and WHM. Qualifications were available at the graduate certificate, graduate diploma and master's degree levels, offered by six education providers – four in the university sector and two private providers (Lin et al., 2005: 128).

By 2021 two postgraduate naturopathy programs (non-clinical) were offered, one at the graduate certificate level and the other at a master's degree level.[48] Both qualifications commenced in 2020 through Southern Cross University and are only available part-time. Research modules are included in both qualifications (see Table 6.3). The Graduate Certificate in Advanced Naturopathic Medicine is delivered entirely online, typically over 34 weeks and must be completed within two years. The program has a total of 600 contact hours with three online face-to-face contact hours per subject per week. The program content includes a combination of naturopathy/WHM theory and clinical education in practice-based research.

The Master of Advanced Naturopathic Medicine is delivered fully online, typically over 1.3 years and must be completed within three years. It includes a total of 1200 hours, with three face-to-face contact hours per subject per week. The program content is similar to the graduate certificate with one additional naturopathy/WHM theory subject and three additional subjects in health research and research implementation.

6.6 PROGRAM ADMISSION REQUIREMENTS

In 2003, 70% of private education providers based their admission on academic ability and 29% required completion of Year 12 (Lin et al., 2005: 129). There was some evidence of competition for training places with preference given to students with moderate to high academic achievement.

In 2021, the Endeavour College of Natural Health bachelor's degree required minimum Year 12 or equivalent qualifications, and minimum English language requirements for admission. Students with recent secondary school education are now considered for admission to Torrens University Australia if they have an Australian secondary school certificate. Students who have completed Year 11 will be eligible to have a place reserved for them on condition that Year 12 is subsequently successfully completed and they meet any specific additional program entry requirements.

Nature Care College accepts students who are over 18 years of age. Switch on Health advised admission to its programs requires equivalent Year 12 literacy and numeracy skills, as well as computer literacy skills.

Southern Cross University advised admission to its postgraduate programs requires a bachelor's degree in naturopathy or equivalent and English language requirements.

6.7 NATUROPATHIC EDUCATION ON RISKS AND SAFETY OF TREATMENT

Education of naturopaths on the risks of naturopathic treatment and practice are a core component of the naturopathy program curriculum. There are over 75 resources used in one naturopathy degree level program to educate students on professional responsibilities, adverse effects of naturopathic treatment and interactions with medically prescribed substances. These resources include books, journal articles, herb/drug databases, websites, podcasts, pharmacology, and safe prescribing tools. The information taught to students is scaffolded throughout the degree program particularly in active learning tutorials where students use the tools and materials to apply knowledge via case studies. Appendix 6.2 presents a list of these resources.

48 These qualifications cater for practitioners who already hold naturopathy degree qualifications and wish to upskill.

6.8 EDUCATIONAL ASSESSMENT STRATEGIES

In 2003, a limited range of assessments were used for herbal medicine subjects. The major forms of assessment were closed-book examinations and case studies. These were thought to disadvantage some students and indicated a limited awareness of good educational practice (Lin et al., 2005: 129).

The 2021 survey of education providers indicated that the predominant forms of assessment were assignments or essays and examinations, although there were a variety of other assessment types for individual programs. These include quizzes, presentations, case studies, and literature reviews. Switch on Health reported open-book examinations for the two programs. There was no information regarding assessments in the Nature Care College prospectus or on the website.

6.9 STUDENT PROFILES

Applications and enrolments

In 2003, there were a total of 3,719 enrolments across the program range, made up of:

- 1602 advanced diploma enrolments at 29 campuses;
- 3014 bachelor's degree enrolments at eight campuses;
- 559 program conversion enrolments at 5 campuses; and
- 146 postgraduate enrolments at seven campuses (Lin et al., 2005: 130-1).

In 2021, while there were changes to the mix of enrolments, there was a similar number of enrolments overall, with a total of 3,335 enrolments made up of:

- approximately 100 enrolments in advanced diploma programs provided at one campus;
- in excess of 3,214 bachelor's degree enrolments provided at nine campuses;
- 21 enrolments in postgraduate programs at one campus.

This figure does not include enrolments at Nature Care College for which no information could be found.

No conversion programs (for diploma qualified practitioners to upgrade to bachelor's) were found. However, block credit agreements exist for those wanting to upgrade from an advanced diploma to a degree for those that meet the recency of qualification requirements.

Planned education programs

In 2003, 33 campuses were planning further undergraduate or postgraduate programs within a five-year timeframe (Lin et al., 2005: 134).

In 2021, Southern Cross University reported plans to launch two additional programs that integrate into a clinical program. These have now been established and are into their second year of delivery – Bachelor of Health Science (Health & Lifestyle) (with a nested Diploma of Health (Naturopathic Studies Specialisation)), and Master of Naturopathic Medicine offered at the Gold Coast and Lismore campuses.[49] South Cross University advised:

> *This clinical program features multiple entry and exit points, allowing development of naturopathy pre-clinical and clinical skills based on student previous knowledge. For example, students with no previous health background can follow 3+1 pathway (3-year Bachelor + 1-year Master) and students with previous health background (e.g. nursing) can enrol directly into a 2-year Master of Naturopathic Medicine using a graduate entry pathway. This integrated degree arrangement also allows naturopathic practitioners with Advanced Diploma-level degrees from accredited institutions and established clinical experience, upgrade their qualifications using defined block credit arrangement into Master of Naturopathic Medicine. Master of Naturopathic Medicine and 3+1 clinical pathway have been recognised by all Naturopathy associations (as per Table 6.2) and accredited by professional body (ARONAH).*

Publications and research grants

In 2003, academic staff of naturopathy/WHM programs who had published research in peer-reviewed journals were all employed by universities and suggested there was a lack of research and scholarship culture in the private education sector. The Lin Report also found that a number of external research grants had been awarded to academic staff in the five years to 2003 totalling almost AUD$1.5 million. Approximately 90% of these funds were provided by the private sector (Lin et al., 2005: 146).

In 2021/2022 all education providers reported that academic staff had published peer-reviewed articles in the previous five years although no details were available as to how many staff and the strength of their publications record.

Two education providers, Southern Cross University and Torrens University Australia reported their staff had received funding from external funding bodies in the previous five years, though detailed information was not provided on the funding source or grant amount.

49 Southern Cross University advised that this clinical program features multiple entry and exit points, allowing development of naturopathy pre-clinical and clinical skills based on students' previous knowledge. For example, students with no previous health background can follow 3+1 pathway (3-year bachelor's + 1-year master's) and students with previous health background (e.g. nursing) can enrol directly into a 2-year Master of Naturopathic Medicine using a graduate entry pathway. The integrated degree arrangement also allows naturopathic practitioners with Advanced Diploma-level degrees from accredited institutions and established clinical experience, upgrade their qualifications using defined block credit arrangement into a Master of Naturopathic Medicine.

A Southern Cross University website news report of 28 November 2018 indicates that the University received a gift of AUD$10 million from the Blackmore Foundation to establish a National Centre for Naturopathic Medicine for higher education, research, and engagement with the profession.[50]

Switch on Health reported that its staff may have received funding from external funding bodies in the previous five years with no further detail provided on grant amount or funding source.

No information was found regarding grants awarded to Endeavour College of Natural Health or its staff, nor Nature Care College or its staff.

6.10 VIEWS OF EDUCATION PROVIDERS

In both the 2003 and 2021 surveys, participants were asked open questions about the regulation of the naturopathy profession, education in naturopathy, and other concerns regarding political, governmental, or legal issues relevant to education.

Regulation of naturopaths

In 2003, ten (53%) of education providers surveyed indicated a preference for statutory registration, four (28.5%) supported a co-regulation model, and one (7%) preferred self-regulation (Lin et al., 2005: 141).

In 2021, two education providers reported they supported statutory registration for the naturopathy profession, one reported support for the current model (of voluntary certification/self-regulation) for naturopaths and herbalists, and no information was available on the views of the other two providers.

Future of education of naturopaths in Australia

In 2003, 65% of education providers surveyed supported bachelor's degrees as the appropriate minimum level of education for naturopaths and herbalists (Lin et al., 2005: 142). Bachelor's level minimum education was considered inevitable and necessary for practitioners wishing to move into research, education and higher university degrees. It was also seen as good for the profession. Concerns were identified in the areas of preparation for clinical practice, adequate supervision of clinical practice before and after graduation, and standards of education in the vocational training sector. There was strong support among education providers in 2003 for research and higher degrees although concern was expressed regarding the diminution of the holistic underpinnings of naturopathy/WHM and an overreliance on evidence-based medicine and scientific approaches (Lin et al., 2005: 143). The drive for raising education requirements was expected to come from increasing public interest in naturopathy and WHM, though there was some concern for the future of graduates as training in capital cities was seen to have reached capacity, with predictions that most graduates would be unable to find long-term employment (Lin et al., 2005: 143). Conflicts in the profession were seen to be due to differences over education and regulation, where independence and transparency of accrediting bodies, and commercial interests being particular sources of concern (Lin et al., 2005: 144).

Similarly, in 2021, education providers expressed a diversity of views regarding the future of education of naturopaths in Australia, the threats and opportunities.

Future of naturopathic education

Southern Cross University considered the future of naturopathic education in Australia to be at the postgraduate level for entry into clinical practice with a stronger focus on evidence-based practice, integrative health care models, and consistency of practice. The University's existing postgraduate programs at graduate certificate and master levels were aimed at extending practice for existing degree qualified naturopaths.

Switch on Health reported that its private program offerings, run by naturopaths rather than businesses provided a brighter future for the profession. It expressed opposition to bachelor's degree minimum qualifications for entry to practice in naturopathy and considered such a move would be counter-productive to the growth and survival of the profession in Australia. A well-designed and well-delivered advanced diploma based on content and quality as determined by professional associations was considered an appropriate entry level to the profession. The College expressed the view that while its advanced diplomas could meet all accreditation standards set by an association such as the NHAA, its programs would not be accredited because they are not delivered at the bachelor's degree level.

Torrens University Australia expressed support for the bachelor's degree as the minimum qualification for entry to practice as a naturopath and considered that in the future, a bachelor's degree would remain the minimum qualifying award for the title of naturopath. It expected there would be more opportunities for postgraduate education in naturopathic and WHM research and more discipline specific postgraduate qualifications to expand expertise, scope of practice and research capacity, with education pathways established through to doctoral degrees.

Opportunities for naturopathic education

Southern Cross University reported opportunities in the movement of naturopathy education back to the university sector, with a potentially stronger focus on evidence-based practice, integrative care, and consistency of practice. Postgraduate offerings and cultivating connections with local industry and health services were also viewed as opportunities for the University.

Switch on Health reported growing and improving the quality of its programs and providing opportunities to study naturopathy/WHM for those who would

50 See $10m philanthropic donation from the Blackmore Foundation and Our history.

otherwise not have the chance were considered the main opportunities.

Torrens University Australia expressed the view that registration of the profession could provide opportunities to expand into integrative health care systems and community health. They reported there would be opportunities for naturopaths to be leaders in community health promotion and prevention, community education, aged care, childcare, chronic disease management, health and self-care education, and the use of naturopathy as first line treatments for certain conditions.

Threats to naturopathic education

Southern Cross University reported that the lack of insurance rebates, hostility and opposition from groups such as Friends of Science in Medicine, the return of the so-called advanced diploma qualifications, and the ongoing need for funding streams as threats to naturopathic education.

Switch on Health reported concerns regarding the marked reduction in the number of education providers and detailed the acquisition histories of private education providers as examples of the deteriorating state of education of naturopathy/WHM, a potential portent of the demise of some program offerings. Increased government regulation of qualifications or any move to establish bachelor's degree as the minimum for entry to practice was considered likely to reduce the quality of naturopathy/WHM qualifications. Previous attempts to regulate and enforce national standards in qualifications were considered to have led to qualifications that were not fit for purpose and were mismatched to standards required by professional associations at the time. Switch on Health considered Training Package qualifications detrimental to the quality of complementary medicine education and facilitated the 'rorting' of students and taxpayers (via VET Fee-help) by 'unscrupulous providers'. The bachelor's degree minimum standard was not seen to protect students, citing evidence of the closure of an educational institution providing bachelor's degree education.

Torrens University Australia indicated concern about the re-appearance of unaccredited programs and the variety of qualifications that did not meet minimum education standards set by government. These programs were considered to put the public at risk from underqualified practitioners who may not have the necessary skills and knowledge to enter practice and to treat complex health conditions safely. The resulting confusion surrounding the level of qualification and training for naturopaths was considered partly due to government inability to enforce minimum training standards. This was viewed as a barrier to acceptance of the profession by the wider community and health sector. Unaccredited programs were considered likely to misinform prospective students about required professional standards. Registration was considered a way of protecting occupational titles, facilitating standardisation of qualifications, and improving the reputation and acceptance of the profession. Removal of private health fund provider recognition was seen as affecting consumer access to naturopathic services and consumer and medical profession confidence in the profession because of a purported lack of clinical evidence. Lack of statutory registration was considered to curtail opportunities for naturopaths to participate in interprofessional communication and collaboration, although statutory registration accreditation was also seen as a threat to the viability of some programs. Broader threats identified were climate change, economic instability, changes in student demand, and political and legislative changes.

6.11 COST OF NATUROPATHY PROGRAMS

Education providers were asked for information on the costs of their respective programs.

Given the diversity of naturopathy and WHM programs currently on offer, the costs also vary greatly (see Table 6.5).

Table 6.5: Cost of naturopathy and WHM programs (costs correct as of 2022)

Provider	Award	AUD
Undergraduate programs		
Endeavour College of Natural Health	Bachelor of Health Science (Naturopathy)	$73,999
Torrens University	Bachelor of Health Science (Naturopathy)	$80,800
Torrens University	Bachelor of Health Science (Western Herbal Medicine)	$60,600
Nature Care College	Advanced Diploma of Clinical Naturopathy	$43,695
Nature Care College	Advanced Diploma of Clinical Western Herbal Practice	3 years: $25,750, 4 years: $26,235
Switch on Health	Advanced Diploma of Naturopathic Practice	$28,153
Switch on Health	Advanced Diploma of Western Herbal Practice	$18,218
Postgraduate programs (non-clinical) ***		
Southern Cross University	Graduate Certificate in Advanced Naturopathic Medicine	$13,000 Commonwealth-supported places available
Southern Cross University	Master of Advanced Naturopathic Medicine	$26,000 Commonwealth-supported places available

***Postgraduate program fees do not include fees required to gain undergraduate prerequisites for postgraduate admission.

Table 6.6: Education provider summary table

Education providers	Endeavour College of Natural Health	Nature Care College	Switch on Health	Torrens University Australia	Southern Cross University
Business Structure	Company limited by guarantee	Unknown	Incorporated company	Incorporated company	Statutory authority
Campuses	6	Nil	Nil	3 Offering naturopathy & WHM programs	3
Program delivery mode	On-campus, online, blended	Real time 'virtual classroom' and/or view recording at any time during the College term	Online only	Blended on-campus and online, flipped learning delivery model	On-campus, online
Affiliations	Independent Higher Education Australia	None found	None reported	THINK Education, part of Torrens Global Education, Strayer and Capella Universities (USA).	Regional Universities Network.
Awards	Bachelor of Health Science (Naturopathy)	1. Diploma of Clinical Naturopathy 2. Advanced Diploma of Clinical Western Herbal Medicine	1. Advanced Diploma of Naturopathic Practice 2. Advanced Diploma of Western Herbal Practice	1. Bachelor of Health Science (Naturopathy) 2. Bachelor of Health Science (Western Herbal Medicine)	1. Graduate Certificate in Advanced Naturopathic Medicine 2. Master of Advanced Naturopathic Medicine
Award type	Primary qualifying award	Primary qualifying award advertised as 'job ready'	Primary qualifying award	Primary qualifying award	Postgraduate award
Year awards commenced	1981 (as Australian College of Natural Medicine)	Unknown	2019	1961 (as Southern School of Natural Therapies)	2020[1]

Education providers	Endeavour College of Natural Health	Nature Care College	Switch on Health	Torrens University Australia	Southern Cross University
Completion time frame	4 years full-time 8 years part-time	1. 4 years full-time 2. 3 years full-time or 4 years part-time	1. 4.5 years full-time 2. 10 years part-time	1. 4 years full-time 8 years part-time 2. 3 years full-time 6 years part-time	1. 34 weeks up to 2 years 2. 1.3 years up to 3 years
Number of subjects	40	1.44 2.29	1.38 2.25	1.36 2.24	1.4 2.8
Total program hours	3434	1. 2200 2. 1400	1. 2520 2. 1570	1. 4300 2. 3340	1. 600 2. 1200
- Modality teaching	1479	1. 930 2. 450	1. 1350 2. 600	1. 2040 2. 1560	
- Clinic teaching	1037	1. 520 2. 500	1. 250 2. 250	1. 1060 2. 820	
- Sciences teaching	918	1. 750 2. 450	1. 520 2. 520	1. 1200 2. 960	
Admission requirements	Year 12 or equivalent, English language	Over 18 years of age	Year 12 literacy and numeracy, computer literacy	Australian secondary school certificate Work Life Entry Pathway	Bachelor's degree in naturopathy or equivalent, English language
Regulator/ accrediting body	TEQSA	---	---	TEQSA Via Academic Board	TEQSA Via Academic Board
Student enrolments	2,214 students (2021)	Unknown	Approx. 100 students (2022)	Approx. 1,000 students (2022)	21 students (2020)
Planned education programs	None found	None found	None	None declared	• Diploma of Health (Naturopathic Studies Specialisation) • Bachelor of Health Science (Health and Lifestyle) • Master of Naturopathic Medicine
Preferred regulation for naturopaths and herbalists	Not known	Unknown	Voluntary certification (self-regulation)	Statutory registration	Statutory registration

1. Southern Cross University launched its first naturopathy degree in 1995 & terminated in 2017. The University subsequently relaunched its naturopathy program in 2020.

6.12 DISCUSSION

How has the provision of naturopathy education changed?

In the two decades since the release of the Lin Report the educational landscape for entry to practice in naturopathy has changed considerably. From a baseline of 43 education providers offering 104 undergraduate and postgraduate awards at 47 campuses in 2003 (2005: 8), the current offerings have declined to just nine programs (seven undergraduate and two postgraduate) provided by five educational institutions at 10 campuses. At that time of the Lin Report, almost half of all programs (49%) were established in the previous three years, and approximately 33 further undergraduate or postgraduate programs were in planning (2005: 8).

Some might be concerned about the decline in the number of naturopathy programs and providers. However, the picture is complex and the causes are likely to be multi-factorial.

First, it is possible that the number of providers and programs in 2003 was unsustainable and that these changes mirror a broader trend in the sector towards consolidation, with larger providers better resourced to meet HE accreditation standards. Previous research suggests that the number of programs and providers that were boosted by government financial support outstripped demand (Wardle et al., 2012: 365). Also, prospective students may have sought qualifications and training opportunities that provided a greater chance of job placement following graduation.

Second, while there is no doubt the number of programs, providers and campuses have plummeted, student enrolments may have declined only marginally – approximately 13% (3,245 enrolments in 2021, down from 3,719 in 2003) or not at all given that no enrolment numbers could be found for Nature Care College. If enrolment numbers have indeed declined in the past 20 years it is possible that prospective students without serious career aspirations who may have enrolled in a VET sector program in 2003 are self-selecting out in 2021.

How have changes in government policy impacted the provision of naturopathy education?

The decline in programs and providers may be linked to changes in government higher education policy. In 2005, the Lin Report found an evolving educational landscape, with growth and competition fostering diversity and confounding attempts to establish effective self-regulation with minimum entry level qualifications and practice standards. It also found the involvement of three educational sectors – universities, TAFE institutes, and private colleges, each sector with its own culture and approach to education.

Since that time, government education policy and funding changes have impacted naturopathy education. In 2014, naturopathy programs were removed from the Health Training Package and therefore from the VET sector. Registered training organisations (RTOs) were no longer able to secure funding to deliver Health Training Package naturopathy programs at less than AQF7 (bachelor's degree level). Advanced diploma awards delivered by these RTOs ceased in 2015 and were in teach-out mode until December 2018 (SkillsIQ 2019a: 23).

This policy decision was based on the premise that as naturopaths are independent primary care practitioners with a broad scope of practice, the proper place for training of naturopaths is in the higher education sector with the minimum standard for entry to practice at AQF7 (bachelor's degree). This position is consistent with the classification of naturopathy within the Australian and New Zealand Standard Classification of Occupations (ANZSCO 2024). Under the ANZSCO, the occupation of 'Naturopath' is classified under the broader group of 'Health Therapy Professional'. The ANZSCO classification states 'occupations in this unit group have a level of skill commensurate with a bachelor's degree or higher qualification (ANZSCO Skill Level 1)'.[51] The ANZSCO also states 'registration or licensing may be required'.

The removal of naturopathy programs from the Health Training Package meant ASQA vacated the space as the accrediting body, with TEQSA responsible for accrediting higher education naturopathy programs and providers. Several private providers were already providing degree level naturopathy programs. The data suggests the remainder chose not to upgrade their programs from advanced diploma to degree and instead closed down their VET sector programs.

Taking into account population growth since 2003, the reduction in enrolments is still substantial and renewal of the profession may not be keeping pace with demand. The available data is insufficient to test whether the current graduation rate is sufficient to maintain or grow the naturopathy workforce. A further study would be required to investigate this.

On a positive note, most naturopathy students are enrolled in bachelor's degree programs. Only two providers are offering unaccredited programs at less than bachelor's level, although new provider entrants are always possible. Thus, at least for now, most students are receiving training that is government accredited and to a higher level than most programs available in 2003. Therefore, it is likely that graduates entering the profession are more highly trained and qualified than previously.

It is apparent however that the transition of naturopathy training from the VET to HE sector has not given effect to the intention of government policy. At the time of the policy change, no mechanism was instituted to enforce the accepted minimum standard (bachelor's degree). At the same time, removal of private health insurance rebates for naturopathy/WHM services, the de facto regulatory role played by private health funds in setting bachelor's degree as the minimum for provider rebate status ceased. This combination of factors has left open

51 See ANZSCO.

the opportunity for new providers to enter the market offering programs at less than bachelor's level that are promoted as job ready entry level qualifying awards, but with no government scrutiny (either ASQA or TEQSA) of their quality. International research indicates that countries with workforce regulation frameworks that set minimum qualification requirements for entry to practice report higher and more consistent education standards than those without regulation (Dunn et al., 2021).

One survey respondent expressed the view that scrutiny by government accrediting bodies stifles competition and reduces the availability and accessibility of programs, thus denying many prospective students the opportunity to study naturopathy, arguing that industry accreditation (via a professional association) provides sufficient quality assurance.

However, the evidence suggests that government accreditation assures standards of education and that without sufficient external scrutiny, training standards can be compromised under pressure from commercial interests (Aldridge 2008: 9; McCabe 2008: 174; Young 2019: 402).

Other primary care professions have made the transition to the HE sector. Chinese medicine, chiropractic, and osteopathy have a similar risk profile but have a statutory regulator that has enforced a minimum qualification at degree level. This is not the case for the naturopathy profession, where research also shows that up to 55% of naturopaths (Braun et al., 2013: 60; Steel et al., 2017: 7; Steel et al., 2020: 3) and up to 80% of herbalists hold qualifications lower than degree standard (Braun et al., 2013: 60; Steel et al., 2017: 7).

Degree trained practitioners, with a strong grounding in biomedical sciences and robust clinical training are more likely to be safe and competent to practise naturopathy than those graduating from unaccredited online programs.

Education provider representatives of degree programs indicated their support for statutory registration of naturopaths and herbalists and supported degree-level education for entry to practice. One provider of diploma programs opposed degree-level education for naturopaths due to concerns over the impacts on the profession of such a move.

Four out of five of the professional associations that represent naturopaths have set bachelor's degree as the minimum qualification for practising membership. The World Naturopathic Federation has issued a Naturopathic Educational Program Guide (2022) about standards of training for naturopaths (WNF 2022) and has granted Education Membership only to those educational institutions in Australia that provide degree level naturopathy programs. The WNF Guide states:

> ***Full members of the WNF are national naturopathic associations that recognize the highest educational standards in their country. Although the WNF recognizes a 2500-hour and 4000+-hour program, the expectation and recommendation is that each country adopts only one standard: the highest naturopathic educational standard permitted in their country (WNF, 2022: 2).***

Are naturopathy graduates being adequately prepared for naturopathic practice?

In 2003, only 21.1% of naturopaths and herbalists reported being well-prepared by their training in Western diagnostics, 27.9% reported being well-prepared by their clinical training, 33.8% reported being well-prepared by their medical sciences training, 48.6% reported being well-prepared by their natural therapies training and 10.7% being well-prepared for inter-professional communications to enter professional practice (Lin et al., 2005: 112). More recent data suggests preparedness for practice continues to be challenging for graduate naturopaths (Leach et al., 2021; Steel et al., 2023).

While the evidence suggests standards of training have improved, as in 2003 there continues to be considerable variability across the naturopathy and WHM curricula, naturopathic modality, sciences, and clinical practicum. Student contact hours vary markedly across the institutions. Bachelor's degree naturopathy programs require 4300 study hours or more, while the Advanced Diploma naturopathy programs range between approximately 2500 to 3200 study hours. Accompanying the shift to HE, programs now assess students according to learning outcomes and use more flexible modes of delivery. Therefore, contact hours are of limited use in comparing programs. Modes of delivery range from blended in-person/online learning for degrees to fully online learning for Advanced Diplomas. Assessment methods varied from a combination of assignments, essays and examinations for degree programs to open-book examinations for diploma programs.

Of concern is the clinical practicum arrangements of some programs. The program with the largest clinical component (600 hours) is nearly two and a half times greater than the program with the fewest clinical teaching hours (250 hours). Two education providers of bachelor's degree programs reported operating student clinics where students are supervised by teaching staff for 460 or 731 hours (depending on the program provider). Under these arrangements, students would be expected to receive a broader range of clinical experiences and a thorough assessment of practice competence. Nature Care College runs a live online student clinic which students must attend for 200 or 100 hours depending on the program and a further 200/100 hours with an approved clinical practitioner. In contrast, the fourth provider has no student clinic and students are expected to be supervised by external practitioners for between

200 and 400 hours. There is no scrutiny of external practitioners by a government education regulator for either Nature Care College or Switch on Health.

It appears that despite the passage of nearly two decades since the release of the Lin Report, naturopathy and WHM education are no closer to a commonly agreed minimum standard for undergraduate naturopathy and WHM education, nor is there agreement about what proportion of program hours should be devoted to the core subject areas and clinical practicum.

Is industry self-regulation working?

Reliance on professional associations to enforce minimum education standards for entry to naturopathic practice continues to be unsuccessful. As in 2003, it is likely that some graduates are poorly prepared for naturopathic practice and as a consequence are not adequately attending to the health and safety of their patients (Lin et al., 2005: 153).

Professional associations been unable to reach a consensus on and enforce a common minimum education standard for entry to practice at bachelor's degree level, with ATMS seeking to reverse the 2014 decision and reinstate advanced diploma programs in the VET sector Health Training Package (SkillsIQ 2019b: 18, 20, 23). The SkillsIQ Industry Skills Forecast report of 2019 recommended reinstatement of advanced diploma qualifications for naturopathy and WHM within the Health Training Package (SkillsIQ 2019a: 19, 21). However, SkillsIQ appears not to have consulted widely prior to making this recommendation, with only ATMS – only one of the five professional associations of naturopathy listed as a stakeholder – consulted in preparing the report (SkillsIQ 2019b: 19, 25-29).

Furthermore, in April 2019 the Australian Government removed provisions for private health insurance rebates for naturopathy and WHM.[52] This exposed the public to additional risks by removing one of the few protections in place that allowed the public to identify appropriately trained naturopaths and WHM practitioner because eligibility for rebates was reliant on practitioners joining a professional association to access private health insurance provider numbers for patient use when claiming rebates.

Limitations of this study

The survey responses in 2021 were not as comprehensive as those provided to the Lin Report, with limited data provided on staffing (qualifications, numbers), student demographics, and graduate completions. Also, one provider chose not to participate in the survey.

The Lin Report was a government funded, commissioned and overseen review of the state of naturopathy and WHM in Australia. The imprimatur of government sponsorship may have encouraged greater participation than in the current survey. The areas not covered in the present study due to lack of data are:

- Conversion programs
- Short courses
- Student numbers, age and gender by program type, previous qualifications
- Graduate completions
- Academic profile of education provider staff
- Qualifications and clinical practice experience of academic staff.

6.13 CONCLUSIONS

There are five known education providers of naturopathic programs in Australia, two residing in the university sector and three private providers. The programs offered by the two universities and one private provider are accredited under arrangements with the government authority TEQSA, and these educational institutions have governance arrangements such as Academic Councils, Boards, and/or Committees to oversee course programs. The two remaining private provider programs are not accredited by any government education authority.

The quality of programs varies markedly between degree level programs and the others, particularly with respect to student contact hours and arrangements for clinical training. Providers of degree and below degree level programs hold disparate views regarding the educational requirements for naturopathic practitioners, the regulation requirements for the profession, and the future of naturopathy.

In 2005, the Lin Report recommended the establishment of an independent regulatory body to determine uniform minimum educational standards for the professions of naturopathy and WHM. It was recommended that the naturopathic profession work towards a bachelor's degree as the minimum requirement for practice entry, and that clinical education be reviewed and minimum standards set to ensure graduate competence. Clinical teachers were recommended to have a minimum of five years full-time equivalent experience (Lin et al., 2005: 174). None of these recommendations have been implemented.

Despite some progress in establishing education standards, there remains no unified national standard for the minimum qualifications required for entry into these professions. This variability leads to inconsistencies in practitioner competence and has flow on effects both for public confidence in the professions and for public safety.

At the present time, four out of five national professional associations have set bachelor's degree level naturopathic/WHM qualifications as the minimum required for practitioner membership. One professional association (ATMS), and more recently, several educational institutions continue to support reverting to an advanced diploma qualification as the minimum qualification for entry to practice as a naturopath or WHM practitioner.

52 See Changing coverage for some natural therapies.

This division within the profession over minimum entry to practice education standards is now a four decade-old struggle (Lin et al., 2005: 151), one that is unlikely to be resolved without government intervention.

Establishing and enforcing a national standard for education of naturopaths and herbalists would ensure that all practitioners meet a minimum level of competence, thereby improving the quality of care provided to the public and reducing the risks of harm outlined in **Chapter 3**.

7
PROFESSIONAL REPRESENTATIVE ARRANGEMENTS FOR NATUROPATHS & HERBALISTS

Anne-Louise Carlton

7.1 INTRODUCTION

A professional association is defined as a body of persons engaged in the same profession or occupation, formed usually to control entry to the profession, maintain standards, and represent the profession in discussions with other bodies (Collins online dictionary).

Most health professions will have one or more professional associations that represent the interests of members. Such associations often play a key role in setting professional, ethical and educational standards, and in representing the interests of their members to government, private sector institutions, and the public (Lin et al., 2005: 157).

The Lin Report (2005) presented the findings of a survey undertaken in 2003-04 of professional associations that represented naturopaths and herbalists. The criteria for inclusion in the survey were that the association had to profess a key role in the representation and development of standards of the professions of naturopathy or WHM or in the representation of practitioners who use naturopathic or WHM modalities.

The purpose of this chapter is to present the findings of a similar survey undertaken in June-July 2021. Survey data was supplemented by searches of publicly available information posted on the websites of professional associations, including for those associations that did not respond to the invitation to participate in the survey. Using both data sources, this chapter presents key features of the professional associations that represent naturopaths and herbalists, including their membership profiles, codes and guidelines issued, standards, policies and procedures, and views about regulation and other issues of importance to the profession. The term 'organisation' is used throughout this chapter, encompassing the different types of entities captured in the data collection.

7.2 METHODOLOGY

Seventeen organisations were identified using the original list of professional associations from the Lin Report (2005). This list was checked for currency using various search strategies, including reviewing government reports, Google searches, information from health funds and consultation with key informants (ANC members). The same criteria used in the Lin Report survey were applied to identify associations to be invited to participate in the survey, that is, the professional body had to profess a key role in the representation and development of standards for the professions of naturopathy/WHM or in the representation of practitioners who use naturopathic or WHM modalities.

Qualtrics Survey Software was used to develop the survey tool. The questions were based on the original survey questions included in the Lin Report instrument but were updated and adapted to facilitate online data collection. A draft survey tool was piloted by the members of the ANC Research Reference Group.[53]

Ethics approval was obtained from the Southern Cross University's Human Research Ethics Committee.

The search found that most of the 17 associations listed in the Lin Report were either no longer in existence or no longer operating under their original name. Six organisations met the survey inclusion criteria and were sent an email invitation to participate, along with a link to access the survey tool. Also included was an information sheet and a consent form.

The survey tool was distributed in the first week of June 2021. Three organisations had not responded by the due date and were notified of an extension. Organisations that had not responded by the extension date were followed up by telephone and email.

53 See Changing coverage for some natural therapies.

Information sought in the survey tool about each organisation included:

- structure and administration
- aims and purposes
- legal status – instrument of incorporation and rules of association
- membership classes and eligibility requirements
- codes of ethics and practice guidelines
- policies and procedures
- current issues and concerns
- policy position on statutory registration regulation

Information collected via the survey was supplemented by a search of the websites of each of the six organisations for relevant publicly available information. Templates were prepared to facilitate comparative analysis. These templates were populated for all six organisations within scope, including the three associations that did not participate in the survey.

The findings of the survey and website search are presented below under four main headings:

- key features of professional organisations
- membership
- policies and procedures (including complaints processes), and
- current concerns of professional organisations

7.3 KEY FEATURES OF NATUROPATHY AND WESTERN HERBAL MEDICINE PROFESSIONAL ORGANISATIONS

Number of professional organisations

In 2005, Lin & colleagues found there was a proliferation of professional associations established during the period 1982-2002. There were 17 eligible associations invited to participate in the survey of which 14 responded (2005: 158). Twenty years later, despite extensive internet searches, ten of these associations could not be located and it is assumed they are no longer in operation.

Appendix 7.1 compares the list of eligible and included associations in 2004-05 with those included in the current study. In the current study, only five associations were found that met the inclusion criteria. They were:

- Australian Natural Therapists Association (ANTA)
- Australian Naturopathic Practitioners Association (ANPA)
- Australian Traditional-Medicine Society (ATMS)
- Complementary Medicine Association (CMA)
- Naturopaths and Herbalists Association Australia (NHAA)

A sixth organisation, the Australian Register of Naturopaths and Herbalists (ARONAH) was also included, although it operates on a different model – as a voluntary (non-government) registering body of the profession rather than as a professional association with representative functions (discussed further below).

Three out of six organisations responded to the survey (ARONAH, CMA and NHAA) (see Table 7.1), a response rate of 50%. Three eligible professional associations (ANTA, ANPA and ATMS) did not respond to the survey. No reasons were provided.

Year of establishment, history, and professions or disciplines represented or covered

Table 7.1 sets out data from the website mapping and survey responses on year of establishment, history, and scope of representation of the six organisations.

NHAA is the oldest of the professional associations, established in 1920, followed by ANTA in 1955 and ANPA in 1975. ARONAH is the most recently established organisation, formed in 2009.

Of the six organisations, three are multi-profession associations (ANTA, ATMS and CMA) and two represent naturopaths only, or naturopaths and herbalists (ANPA and NHAA). ARONAH's register covers both naturopaths and herbalists. These latter organisations all display prominently on their websites their credentials as single modality organisations. Of the three multi-profession organisations:

- ANTA's website stated that it represents 13 'accredited disciplines'
- CMA listed six 'modalities' that are considered 'ingestive'
- ATMS's website listed 19 'modalities'[54]

All six organisations published information on their websites information on their history. All stated that they are national organisations with a national membership/ registrant base, and all reported having their own premises.

54 The FAQs on the ATMS website refer to 25 modalities and its Accreditation Guidelines refer to 22 modalities.

Table 7.1: Information published on websites of organisations about their establishment, history, & professions represented/covered

	PROFESSIONAL ASSOCIATIONS					VOLUNTARY REGISTER
Name of organisation	Australian Natural Therapists Association (ANTA)	Australian Naturopathic Practitioners Association Inc. (ANPA)	Australian Traditional-Medicine Society (ATMS)	Complementary Medicine Association (CMA)	Naturopaths and Herbalists Association Australia (NHAA)	Australian Register of Naturopaths and Herbalists (ARONAH)
Responded to survey	NO	NO	NO	YES	YES	YES
Year of establishment	1955	1975	1984	1985 (NSW) 2000 (Company)	1920	2009
History of organisation outlined	YES	YES	IN PART (slide show)	YES	IN PART	YES
Professions, disciplines, or modalities represented or covered	13 'accredited disciplines': acupuncture, aromatherapy, Ayurvedic medicine, Chinese herbal medicine, homeopathy, musculoskeletal therapy, myotherapy, naturopathy, nutrition oriental remedial therapy remedial massage therapy shiatsu massage Western herbal medicine	Naturopathy	19 'modalities': acupuncture aromatherapy, Ayurvedic medi-cine, Bowen, Chinese herbal medicine, Chinese massage, chiropractic, homeopathy, hypnotherapy, kinesiology, naturopathy, nutrition, osteopathy, reflexology, remedial massage, shiatsu, Thai massage, Tibetan medicine, Western herbal medicine	Naturopathy, homeopathy, nutrition, Western herbal medicine, Chinese herbal medicine, Ayurveda	Naturopathy and Western herbal medicine	Naturopathy and Western herbal medicine

Governance, structure, membership, and resourcing

Table 7.2 sets out data from the website mapping and survey responses on the governance arrangements of organisations, including their legal identity or instrument of incorporation, constitution, board structure, membership and remuneration, mission, and staffing.

Legal identity and constitution

The three professional associations (ATMS, CMA and NHAA) provided a link on their website to their constitution – all are companies limited by guarantee. ARONAH is also registered as an Australian Public Company limited by guarantee. For the remaining associations (ANTA and ANPA), no information was located on their respective websites concerning the instrument of incorporation or constitution.

Board structure and membership

The websites of five out of six organisations provided a list of their Board members (ANTA, ANPA, ARONAH, ATMS, and NHAA).

ARONAH, ATMS and NHAA provided both a photo and short bio for each Board member. The websites of three out of six organisations provide a description of the process for appointment of Board members (ARONAH, ATMS, and NHAA). The ARONAH website has a webpage describing how its inaugural board was appointed (via an independent and competitive process). For ATMS and NHAA, the information on appointment processes is available in their respective constitutions.

In 2004-05, for all but one of the 14 respondent associations (ATMS), the members were eligible to stand for election to the board, hold office, and vote for office bearers. Since that time, ATMS has adopted a new constitution and governance structure that provides for the members to elect up to 9 board members (with two

55 NHAA advised that its financial statements are published in the members only section of its website.

appointed board members).

In terms of gender balance, of the five organisations that provided details on their websites regarding board membership, all except for ANTA had a majority of female members, while in most cases, leadership positions, such as president, were occupied by males.

Board member remuneration

With respect to payment of sitting fees for Board members, it was unclear in some cases whether board members were being reimbursed for their roles. Except for ARONAH, no annual reports or financial statements were publicly available on websites.

The constitutions of four organisations (ARONAH, ATMS, CMA, and NHAA) make provision for remuneration as follows:

- *Article 11.7* of the ATMS constitution provides for the ATMS Board to pay from funds of the Society remuneration to Board members, to a maximum of $250,000 per annum. This limit may be changed by a vote of members. Other expenses are reimbursed if properly incurred.
- *Article 59* of the ARONAH constitution provides that Directors may receive remuneration for their services as approved by all Directors. Analysis of the financial reports of ARONAH suggests that no sitting fees are being paid.
- *Article 14* of the CMA constitution provides that Board Directors are not remunerated for their services but may be reimbursed for expenses.
- *Article 9.4* of the NHAA constitution provides that Directors are not eligible to be paid a fee for their service as a Director, except for reimbursement for out-of-pocket expenses reasonably incurred.

No information was found on remuneration for ANPA or ANTA Board members.

Governance and decision-making

Four out of six organisations provided a description on their website of their governance and decision-making processes. For three of these (ARONAH, ATMS, and NHAA) this information was contained in their constitutions. For the remaining organisations (ANTA, ANPA, and CMA), no information was located on their websites about their governance and decision-making processes.

Only ARONAH provided on its website a board member code of conduct and a policy on how conflicts of interest are dealt with.[56]

Staffing

The websites of three out of six organisations provided information on staffing (ANPA, ATMS, and NHAA); NHAA also provided photos and bios of staff. Only the ANPA website provided an organisational chart.

It was not always clear from the websites of some organisations whether they have paid staff or rely principally on honorary office holders to carry out their functions.

Of the three organisations that responded to the survey (ARONAH, CMA, & NHAA), all indicated they have paid staff and all three reported that in the previous five years they had employed outside expertise in the form of consultants.

The ATMS website listed the staff of the organisation. No indication could be found on the ANTA website as to whether it has paid staff. The ANPA website stated that it operates through volunteers and it was not clear whether ANPA had any paid staff.

Regional structure & operations

Two out of six organisations published information on their website that indicated they were operating via a regionalised structure (ANPA and NHAA), with the NHAA website showing evidence of active state/territory 'chapters'.

56 See ARONAH Board Code of Conduct.

Table 7.2: Information published on the websites of organisations about their governance arrangements

	PROFESSIONAL ASSOCIATIONS					VOLUNTARY REGISTER
Name of organisation	ANPA	ANTA	ATMS	CMA	NHAA	ARONAH
Constitution/rules of association accessible through website	NO (model rules published)	NO	YES Company limited by guarantee	YES Company limited by guarantee	YES Company limited by guarantee	YES Company limited by guarantee
Description of governance and decision-making procedure	NO	YES	YES (in constitution)	YES (in constitution – 18.6 & 38 & 41)	YES (in constitution)	YES (in constitution)
Conflict of interest policy	NO	NO	NO	YES (in constitution – 16)	NO	YES
Organisational structure	YES	NO	Description No diagram	NO	NO	NO
Membership of governing board available	YES	YES	YES Photos & bios	NO (Upgrading website)	YES Photos & bios	YES Photos & bios
Board member appointment method/process	NO	NO	YES (in constitution)	YES (in constitution)	YES	YES
Board member remuneration	No information found	No information found	Constitution allows up to $250,000 per annum	Not remunerated Expenses reimbursed only	Not remunerated Expenses reimbursed only	Constitution allows but none currently paid
Board member code of conduct	NO	NO	NO	YES (in constitution)	NO	YES
Gender balance on governing body	All female	6 male, 3 female	7 female, 2 male	Not found (upgrading website)	All female	6 female, 1 male
Lay or 'community' members on governing board	NO	NO	YES (appointed directors	NO	YES (2 'independent' board members)	YES (3 'community members')
Mission and purpose explained	YES	YES	YES	YES	YES	YES
Staffing information	YES	NO	YES (names)	NO	YES Photos & bios	NO
Regional structure	YES	NO	In part – appoints state/territory representatives	YES State Auxiliaries	YES Four regional chapters	NO
Link to annual reports	NO	NO	NO	NO	Members section only (no financial statements)	Chair's Report (no financial statements)
Link to Strategic goals/plan	NO	NO	YES	NO	NO	NO
Link to latest news	YES	YES	YES	NO	YES	YES
International memberships/ Relationships	None found	NO	None found	YES – Full member of World Naturopathic Federation	YES – Full member of World Naturopathic Federation	YES – Non-profit partner (Bronze) of World Naturopathic Federation

Objects, mission, and purposes

In 2005, Lin & colleagues reported the results of a thematic analysis of the aims and purposes of each of the respondent associations, as set out in their respective instruments of incorporation (2005: 160).

A similar analysis was undertaken for four organisations in the present study, where their constitution was published on their website (ARONAH, ATMS, CMA, and NHAA). For the remaining two organisations (ANTA and ANPA), information was sought from respective websites.

Appendix 7.2 presents available data on the objects, mission, and purposes for the six organisations.

Five out of six organisations provided an explanation on their website of their mission and purpose (ANTA, ANPA, ARONAH, ATMS, and NHAA). Only ARONAH provided links on its website to its annual reports/Chair's reports and only ATMS provided a strategic plan.

Analysis of the website mapping and survey data showed:

- The aims or purposes of ATMS, CMA, and NHAA were similar. Each organisation had objects that relate to promoting or advancing the interests of the profession/membership of the organisation, ensuring high standards of education, research and practice, and advocating on behalf of the profession or membership.
- The ATMS constitution also stated as an object 'to collaborate with stakeholders towards a national occupational regulatory system for the profession of Natural Medicine' although it is not clear what a national occupational regulation system is.
- The ANPA website states '*Our mission is focused on providing the public the highest standard of naturopathic care from our members*' but no further detail could be found on the objects of the association.
- The structure and objects of ARONAH were framed differently to the other organisations – while an important role is to advocate for statutory registration for the profession, the ARONAH website stated that it is established to provide minimum standards of education and practice for naturopathy and WHM and that its Register has been '*developed to mirror government requirements for the regulation of health practitioners*'.[57]

No information could be located on the ANTA website about its purpose, mission, or objectives.

Organisational affiliations

In 2004-05, data was gathered on the affiliations of participating professional associations. These affiliations were categorised as follows:

- inter-association affiliations
- educational institution affiliations
- affiliations with other health-related organisations

In 2005, few affiliations among associations were found and a history of instability and dissolution was evident (Lin et al., 2005: 178).

In this study, analysis of the website mapping and survey data on organisational affiliations found:

- Three organisations (ARONAH, CMA, and NHAA) indicated that they are members of the World Naturopathic Federation (WNF). As professional associations, CMA and NHAA are full members, ARONAH as a voluntary register is a bronze non-profit partner of the WNF.
- ANPA homepage listed 'Corporate sponsors' as Interclinical Laboratories, BioMedical Nutraceuticals, Metagenics, and Bioclinical naturals.
- The ATMS website showed no specific affiliations. The website described a process for colleges to be 'recognised' as providers of quality training, with an application process to become an ATMS Recognised Provider. This process is linked to ATMS's program accreditation process. The logos of 'approved colleges' are displayed on the website by state and territory.
- The NHAA website had pages which listed 'Our partners' and 'Our Community'. Displayed were details of WNF, OneCAM, ANC, Climate Health Alliance, herbal medicine suppliers, and an insurance broker that NHAA had partnered with to deliver professional indemnity insurance for its members.
- The ANTA website listed one affiliation, the Australian Taxation Office under its 'Affiliations' tab, describing the private ruling it has obtained to enable members from specific classes to practise 'GST free'.

Two developments since 2004-05 are worth noting here.

First, the establishment in 2014 of the World Naturopathic Federation (WNF). The WNF website states that it represents 78 naturopathic organisations from all WHO World Regions, with its role to promote, support, and advance the global naturopathic profession. Textbox 7.1 sets out the requirements for associations to become members of the WNF. Three out of six organisations in this study are members of the ANC – ARONAH, CMA, and NHAA.

57 See About ARONAH.

The website lists three member associations from Australia:

- Australian Naturopathic Federation (ANF)
- Naturopaths and Herbalists Association of Australia (NHAA)
- Complementary Medicine Association (CMA)

The WNF 'strongly recommends that there is only one naturopathic association per country represented as a full member of the WNF'. Of the 33 countries listed that have an association listed as member of the WNF, only Australia has more than one association member.

Textbox 7.1: World Naturopathic Federation requirements for full membership

To become a **full member** of the World Naturopathic Federation an association must meet the following criteria:

- Legally constituted national naturopathic association or federation.
- Voting members of the national naturopathic association must be limited to primarily naturopaths, naturopathic doctors or their equivalent (at least 60%).
- National naturopathic association must recommend the highest naturopathic educational standards available in their country. Note: Based on the World Health Organization (WHO) benchmark guidelines only national naturopathic associations that ensure that all members graduated from a minimum 1500 hour (or equivalent) naturopathic program are eligible for full membership. The organisations must also:
  - have, as part of their membership criteria, a way of verifying the level of education of their members and graduation status.
  - represent a significant percentage (at least 20%) of naturopaths, naturopathic doctors or their equivalent in their country.
- National naturopathic association must not be subject to, or controlled by, any office or age, of government
- It is strongly recommended that there is only one national naturopathic association or federation per country represented as a full member of the WNF.

Full member organisations must:

- have a commitment to levels of training commensurate with delivery of primary care services in their country
- have a commitment to achieving statutory licensure or regulation in their country to ensure appropriate levels of accountability and SECRETARIAT standards in their respective country
- have a commitment to other principles around professionalization as outlined in the World Health Organization's Traditional Medicine Strategy.

Source: WNF website: www.worldnaturopathicfederation.org/full-members/#:~:text=Note%3A%20Based%20on%20the%20World,are%20eligible%20for%20full%20membership.

Second, the establishment in 2019 of the Australian Naturopathic Council (ANC), an umbrella body that represents naturopathy professional organisations and education providers.[58] The ANC website states that eligibility for inclusion in the ANC is based on membership of the WNF.[59]

7.4 MEMBERSHIP

Membership categories and numbers

Table 7.3 presents data from the website mapping and survey responses on membership categories. Of the six organisations:

- all have provision for practising members, variously labelled 'full' (ANTA, CMA, NHAA), or 'accredited' (ATMS) or 'general' and 'limited' (ARONAH). NHAA has two categories of full member, practicing and non-practicing
- all organisations have provision for 'student' members
- all organisations except ANTA have an 'associate member' category
- NHAA has provision for 'corporate' members and ANPA has 'secondary' and 'International' membership categories
- only ANPA has provision for 'fellowship' members
- ARONAH, CMA and NHAA have a specific 'non-practising' membership category
- CMA distinguishes 'full' and 'provisional' membership, and
- ARONAH has provision for both 'general' and 'limited' categories of registration, following closely the registration types under the Health Practitioner Regulation National Law.

58 See ANC.
59 See ANC FAQs.

- Lin & colleagues reported data from 13 associations on their membership numbers for naturopaths and herbalists, noting the following:
- total numbers reported: Naturopaths – 4,217; WHM practitioners – 2,469; an additional 369 practitioners accredited to practise both
- difficulties in ascertaining the exact number of practitioners in Australia because practitioners frequently join more than one association
- 1,778 practising naturopaths and herbalists were identified via the workforce survey, substantially less that the number of memberships reported by associations
- an estimate of a further 16% of practitioners may not be in active practise
- common categories of membership were: fellows, full members, associate members, students, and corporate members, with the requirements for membership varying from one association to another

Despite the decline in the number of professional associations, it remains difficult to determine (from association membership numbers), even in approximate terms, the number of qualified naturopaths and herbalists and those in active practise:

- There is little data available on membership numbers and most associations are vague about their numbers – for example, one association website states 'we represent thousands of practitioners….'.
- ATMS provided membership numbers in its 'Media Kits' up until 2019. The most recent data is for 2018 and reports that of its 10,759 members, 88.6% (9,533) are accredited (that is full) members. 2,422 are accredited for the modality of naturopathy and 2,220 for herbal medicine.
- NHAA and CMA provided membership data on request via email.

Requirements for membership

In 2005, the Lin Report found:

- the minimum requirements for practitioner membership in an association varied from no minimum requirement (that is, individual assessment of each applicant's education and clinical experience) to advanced diploma
- some associations had powers under their constitutions to make individual assessments of applicants who do not have the stipulated educational requirements
- at least one association did not set a minimum educational requirement for naturopaths and WHM practitioners
- six out of 14 associations indicated they had developed accreditation processes for assessing overseas naturopathy and/or WHM practitioner applicants but only one association reported use of a gazetted education authority to assess equivalence with Australian qualifications (2005: 177-79)

Table 7.3 presents data on the requirements for membership, drawn from website mapping and survey responses (ARONAH, CMA, and NHAA).

Qualification requirements

Some organisations require a minimum of an advanced diploma in naturopathy or WHM to qualify for full membership. Others require a minimum of a bachelor's degree in naturopathy or WHM, while accepting some historic qualifications at advanced diploma level. Most organisations distinguish between historic qualifications and currently accredited programs.

Table 7.4 provides a list of the naturopathy and WHM programs that are accredited or approved for membership purposes by each organisation. Key points to note:

- ANTA accepts for membership purposes multiple programs from five education providers, all at bachelor's degree level.
- ARONAH requires a minimum of a bachelor's degree for full (general) membership with only three institutions (Southern Cross University, Endeavour College of Natural Health, and Torrens University) providing approved programs. It also provides a 'grandparenting' pathway for those who hold historic degree level qualifications or an advanced diploma that satisfies specified criteria plus a minimum of two consecutive years of practice between 2009 and 2014.
- CMA accepts for membership purposes those with a minimum of an Advanced Diploma of Naturopathy (HLT60502, 60507, & 60512) or an Advanced Diploma of Western Herbal Medicine (HTL60112), noting on its website:

  In July 2014, the Community Services and Health Industry Skills Council announced that the Advanced Diplomas in Naturopathy, Homeopathy, Nutritional Medicine and Western Herbal Medicine would be dropped from the Health Training Package. As a result of this decision, students in Australia now only have the option of studying a minimum level of Bachelor Degree in order to graduate with the potential to become a Natural Medicine practitioner.

60 See ATMS Media Kits.

Enrolments into the Advanced Diploma programs ceased by the end of 2015. The teach out period announced by the Australian Skills Quality Authority (ASQA) ran out on 31st December 2018.[61]

- NHAA accepts for membership purposes three currently accredited programs (provided by Endeavour College of Natural Health and Torrens University), all at a minimum of bachelor's degree level. It also accepts for membership purposes a list of historic qualifications at both degree and advanced diploma level.
- ATMS accepts for membership purposes those who have completed a program of study approved by ATMS. Providers are approved to deliver naturopathy programs at advanced diploma level (Atwea College, Nature Care College, and Switch on Health) and at degree level (Endeavour College of Natural Health, Torrens University, and Southern Cross University).

All organisations require a current first aid certificate and evidence of current professional indemnity insurance. Some also require a working with children check and/or evidence of continuing professional development (CPD).

Table 7.3: Information on membership requirements and benefits published on the websites of organisations

	PROFESSIONAL ASSOCIATIONS					VOLUNTARY REGISTER
Name of organisation	ANPA	ANTA	ATMS	CMA	NHAA	ARONAH
Membership categories explained	YES Student, Full (new graduate), Full, Associate, Secondary, Tertiary, Fellowship, International	YES Full – manual therapist Full – ingestive therapist Student	YES Accredited, Associate, Student	YES Full, Provisional, Associate, Student, Non-practising, *Nutritional modality equivalency (assessment)	YES Student, Full (practising and non-practicing), Associate, Corporate	YES General, Limited, Non-practising, Associate, Student
Fee schedule published	YES	YES	YES	YES	YES	YES
Membership fees	$350 Students – Free	$330 (plus $110 administration fee) (2023 calendar year) Students – Free	$275 (2022-23) Students – Free for students in ATMS approved programs	$340 (2022-23) Students – Free	$330 (2022-23) Students – Free for students enrolled in NHAA approved degree programs	$120 (2022-23) ($175 dual registration) (Plus new member processing fee $25) Students – Free
Membership standards and requirements published (for full members)	YES Minimum bachelor's degree from accredited school & minimum 200 hrs on-campus study, current senior first aid certificate, current PII, compliance with Code of Ethics	YES Currently accredited bachelor's degree or previously accredited degree or advanced diploma, PII, first aid certificate, Working with children check or police check, IELTS 5 or higher (overseas applicants), 20 CPE points previous calendar year, details of previous clinical practice	YES ATMS approved program of study (or equivalent), 20 points/hours CPD, current PII, current senior first aid certificate, 18 years old, of good character	YES Minimum advanced diploma from RTO or University (or equivalent), PII, current first aid certificate, working with children check	YES Currently accredited bachelor's degree or previously accredited degree or advanced diploma, PII, first aid certificate, CPD – min 30 hours	YES Bachelor's or master's degree from accredited program provider, PII, recency of practice, English language standard, compliance with Code
Application forms published	YES	YES	YES	YES	YES	YES
Membership application available online	YES	YES	YES	YES	YES	YES
Information for overseas-trained applicants	YES	YES	YES	YES	YES	NO

61 See CMA website.

	PROFESSIONAL ASSOCIATIONS					VOLUNTARY REGISTER
Membership data	NO	NO	YES (in Media Kits – latest provided in 2019)	NO	NO	NO
Code of conduct or ethics	YES	Not found	YES	Link to state codes of conduct	YES	YES
Mandatory continuing professional development	Not found (member only access?)**	YES	YES	YES (password protected)	YES	YES
Provision of professional development activities seminars, webinars, podcasts etc	YES		YES	YES (password protected)	YES	NO (accredits external CPD providers)
First aid certificate required for practising members	YES	YES	YES	YES	YES	YES
Professional indemnity insurance required for practising members	YES Minimum – not specified	YES Minimum $2 million	YES Minimum – not specified	YES Minimum $2 million	YES Minimum – details member only	YES Minimum $5 million (single claim)
Information on PII providers	YES (three providers suggested)	YES (Guild Insurance)	YES (GSA)	YES (list of providers)	YES (optional partner with insurance broker, members can choose any broker)	NO
Members eligible for GST-free provider status	Not stated	YES	YES	YES	YES	NO
Members eligible for TGA advertising exemption	YES	YES	YES	YES	YES	NO
Member services area (behind paywall)	YES	YES	YES	YES	YES	NO
Peer reviewed journal	NO	NO	YES Journal of ATMS	NO	YES The Australian Journal of Herbal and Naturopathic Medicine (AJHNM)	NO
Other communications	ANPA Weekly News Update	Quarterly journal 'The Natural Therapist'. ANTA News (e-Newsletter)		None found (e-newsletter in members area)	Monthly e-newsletter & social media channels	ARONAH News (e-Newsletter)
Annual conferences and webinars	Not found	Four free CPE Day events each year	Annual conference, symposia and webinars	None found (in members area)	Annual conference and webinars	NO
Information published on private health fund coverage						
Advice on which modalities covered	NO	NO*	YES	YES (in FAQs)	YES	In part (media releases & submissions)
Advice on PHI rules	NO	NO*	YES	YES	NO	NO
Information on PHI Review	YES	NO	YES	NO	YES	YES
Evidence of advocacy efforts	YES (ANPA submissions)	NO	YES	NO	YES	YES

* Information published on the ANTA website about provider status with private health funds is general in nature and does not provide up-to-date advice for naturopaths about their eligibility.

** ANPA advised that it ensures CPD is maintained.

TABLE 7.4: Naturopathy and WHM programs approved for membership purposes by naturopathy professional organisation

Provider	Program	ANPA	ANTA	ATMS	CMA	NHAA	ARONAH
Advanced Diploma programs							
Atwea College RTO status: Current	Advanced Diploma of Western Herbal Medicine NOTE: HLT 60112 (Teach out)	NO	NO	YES	NO	NO	NO
Nature Care College RTO status: Non-current	Advanced Diploma of Clinical Naturopathy	NO	NO	YES	NO	NO	NO
	Advanced Diploma of Clinical Western Herbal Medicine	NO	NO	YES	NO	NO	NO
Switch on Health ***RTO status***: not found	Advanced Diploma of Naturopathic Practice	NO	NO	YES	NO	NO	NO
	Advanced Diploma of Western Herbal Practice	NO	NO	YES	NO	NO	NO
Degree programs							
Endeavour College of Natural Health	Bachelor of Health Science (Naturopathy)	YES	YES	YES	YES	YES	YES
Torrens University Australia[62]	Bachelor of Health Science (Naturopathy)	YES	YES	YES	YES	YES	YES
	Bachelor of Health Science (Western Herbal Medicine)	YES	YES	YES	YES	YES	YES
Southern Cross University	Master of Naturopathic Medicine	YES	YES	YES	YES	YES	YES

CPD: Continuing Professional Development
CPE: Continuing Professional Education
PII: Professional Indemnity Insurance

Membership fees

In 2005, annual membership fees reportedly ranged from $55 to $300 with the average fee of $195 and the median of $120. For students the range was from nil to $55 (Lin et al., 2005: 168).

Table 7.3 presents data on the fees for full (practising) membership, drawn from the websites of each of the organisations. The data shows that for the 2022-23 financial year, fees range from $120 for ARONAH ($175 for both naturopathy and WHM) through to $350 (plus a 'one off application processing fee' of $35) for ANPA. Most organisations charged over $300 per annum, except for ATMS which charged $275 ($125 for a half year).

Member entitlements and benefits

In 2005, comparative data was reported on a range of member benefits provided by professional associations in areas such as:

- GST-free status for consultation fees
- Certificates of exemption for TGA restrictions on access to advertising of therapeutic goods
- Access to provider status with private health insurers
- Publication of periodicals
- Seminars and conferences
- Submissions to government bodies
- Formal recognition of programs (2005: 166-68)

Table 7.4 presents data on the various member entitlements and benefits that the organisations publish on their websites, supplemented by data from the survey.

Goods and Services Tax exemption status for members of recognised professional associations

The Lin Report outlined the history of the GST exemption for naturopaths and herbalists, including the decision of the Australian Taxation Office (ATO) to allow GST exemption for members of multiple professional associations (rather than a single peak national association), despite lack of agreement between these associations on minimum qualification standards for entry to and practice in the profession (2005: 162).

It appears there have been no significant changes to these arrangements since 2005 The mapping of website information suggests that the GST exemption for naturopaths remains in place.

Four organisations published information on their websites advising members and prospective members of eligibility for GST exemption (ANTA, CMA, ATMS, and NHAA). NHAA advised that it has obtained a private ruling from the Australian Taxation Office that it is a 'recognised professional association' for the purposes of provision of GST-exempt services by its members.

For the remaining organisations, it is not clear whether membership qualifies a practitioner to provide GST-exempt patient consultation fees.

62 Formerly the Australasian College of Natural Therapies (ACNT). Southern School of Natural Therapies became part of Torrens University in 2014.

Therapeutic Goods Administration Schedule 1 list

The advertising of therapeutic goods is regulated under the Australian Government *Therapeutic Goods Act 1989* and associated legislative instruments.

In 2005, the TGA (which is responsible for administering the Act) regulated access by natural therapists to advertising material on therapeutic goods (Lin et al., 2005: 163). Since that time, while the relevant provisions of the Therapeutic Goods Act have been amended, the arrangements remain largely the same as in 2005:

- Part 5-1 of the TG Act regulates the advertising of therapeutic goods. However, under section 42AA, certain advertising is exempt from the requirements of Part 5-1, including advertising that is directed exclusively to persons who are members of an Australian branch of a body that is prescribed under Schedule 1 of the Therapeutic Goods Regulations 1990.
- Therefore, in order to receive advertising (such as catalogues from herbal medicine suppliers), a practitioner must either be registered under a state or territory law or belong to an association that is listed in Schedule 1 of the Regulations.

Appendix 7.3 contains a copy of Schedule 1 of the Therapeutic Goods Regulations 1990. There are 40 organisations on the list, including ANTA, ATMS, CMA, and NHAA (under its registered name the National Herbalists Association Australia).

The website mapping shows that:

- four organisations provided information on their websites concerning exemption from the Therapeutic Goods Act advertising requirements (ANTA, ANPA, CMA, and NHAA)
- ANTA and NHAA provide specific advice that members are covered by the Therapeutic Goods advertising exemption
- while ATMS is listed in Schedule 1 of the Therapeutic Goods Regulations, no specific advice was located on the website to indicate to members that they are covered by the exemption
- the information on some websites was unclear as to whether members are covered by the exemption
- ANPA's website stated:

  The ANPA is a member of the Federation of Natural and Traditional Therapists (FNTT). Through this membership the ANPA has been proactive in the development of the Schedule 1 listing and TGA exemption certificates for practitioners [and…] The ANPA continues to lobby the government, meet with Health Insurance companies and other relevant organisations to further the professionalization of naturopaths.

However, it appears that FNTT is no longer in operation since searches conducted for this organisation failed to find a website or evidence of any recent activities. Therefore, it is unclear whether ANPA members are covered by the TG advertising exemption.

In 2013, the TGA conducted a public consultation on proposed changes to the Therapeutic Goods Regulations. This included a proposal to update the exemption for health professionals in Section 42AA of the Act, to only recognise health practitioners regulated under the Health Practitioner Regulation National Law.

The NHAA's submission to the TGA, posted on its website, argued against the proposal on various grounds including that it would affect access for naturopaths and herbalists to their tools of trade.

Private health fund recognition

In 2005, most associations reported their members were accepted by numerous private health funds as eligible providers for the purpose of payment of private health insurance rebates to their patients (Lin et al., 2005: 163).

This situation has changed. From 1 April 2019, 16 natural therapies were excluded from private health insurance cover, including the profession of naturopathy. This decision by the Australian Government means that private health funds cannot currently offer cover for any services provided by a naturopath. This decision was made following a 2015 review of the Australian Government Rebate on Private Health Insurance. On 7 April 2019, a further review was announced by the Federal Minister for Health (the 2019-20 Review) and is still underway.

The mapping data shows that while some multi-profession associations have information posted on their websites that promote private health insurance provider rebate status as one of the benefits of membership, some of this information is ambiguous or misleading in that it does not make clear that following the Australian Government policy changes (outlined above), naturopathic treatments are no longer eligible for private health insurance rebates.

For instance, ANTA's website stated that one of the benefits of membership is that '*five of the 'recognised modalities*' are eligible for registration with over 50 Australian health funds' but no details were located on which modalities were eligible.

The ATMS website provided the most comprehensive suite of materials, including evidence of advocacy efforts in relation to the Australian Government decision to withdraw rebates, but with no updates since 2019-20 were found.

Professional indemnity insurance

Four organisations (ANPA, ANTA, ATMS, & NHAA) indicated they had entered into arrangements with insurance providers to provide a group program for their members.

Public registers of members

Table 7.5 presents data on the information published on the public registers maintained by each of the six organisations. All had on-line searchable registers with varying levels of functionality and information.

No organisation published details of disciplinary actions with respect to members although ARONAH published press releases about naturopaths who have been subject to regulatory action by a court or health complaints commissioner and includes information in its annual Chair's Report.

Table 7.5: Information published on the websites of organisations about their registers of members

	PROFESSIONAL ASSOCIATIONS					VOLUNTARY REGISTER
Name of organisation	ANPA	ANTA	ATMS	CMA	NHAA	ARONAH
List of registered practitioners	YES	NO	YES	YES	NO	YES
Online searchable register	YES	YES	YES	YES	YES	YES
Information contained on register	Name, practice address, phone number, web address	Search by practitioner or clinic, name or suburb/postcode: Name, gender, modalities, suburb, postcode, phone number, 'Make a booking enquiry'	Name, member number, modalities, suburb of clinic, phone number, email, website	Name of clinic, name of practitioner, modalities, location (includes street address & map), phone number, email, website, brief description of practice (optional), social media links, Further info link	Name, profile, qualifications, personal contact details – phone number, email, clinic address, service type, areas of interest	Name, suburb & postcode, phone number, division of registration (naturopathy/ Western herbal medicine), type of registration (general, limited, non-practising, associate)
Details of disciplinary cases	NO	NO	NO	NO	NO	NO (Press releases on specific cases)

7.5 POLICIES, PRACTICE STANDARDS AND EXPECTATIONS

In 2005, to maintain the standards of the profession, associations imposed a range of requirements on their practitioner members including: codes of ethics, professional indemnity insurance, first aid training, and continuing professional education (CPE) (Lin et al., 2005: 169). While all professional associations had developed codes of ethics and required professional indemnity insurance and first aid training for all practising members, CPE was a requirement for full membership in only eight out of 11 professional associations (Lin et al., 2005: 169).

The Lin Report noted the important role of professional practice guidelines and presented data on whether associations had written guidelines on a range of professional and clinical issues, including: referral to medical practitioners; accidents, injuries and adverse events; use of scheduled or restricted herbs; and medical immunisation (2005: 172). At that time, most associations were not very active in the development of practice guidelines with only six associations reporting such guidelines and most had to be accessed from a range of other documents such as codes of ethics or journal articles.

Table 7.6 presents data on the information published on the websites of each of the six organisations about policies and practice standards.

Policies and practice guidelines

Only the ATMS website provided a publicly accessible, user-friendly way of accessing relevant policies and guidelines of the organisation, with a tab on its homepage titled 'Policies and Procedures'. Some organisations (such as ANTA & NHAA) provided guidance to members on practice issues, in the form of FAQs. NHAA advised it provides policies and practice guidelines in the member section of its website.

Codes of conduct

All organisations except ANTA published on their websites a code of conduct or code of ethics containing the standards that members are expected to abide by when they join the organisation. The adequacy of these documents was not reviewed.

Only two associations (ANPA and ATMS) referenced on their websites the relevant state and territory Codes of Conduct for unregistered health care workers that apply in NSW, South Australia, Queensland, and Victoria (and have been enacted but not yet commenced in Western

Australia and Tasmania). These Codes of Conduct are important because they contain requirements that are enforceable under law via the prohibition order powers exercised by state and territory health complaints commissioners, and it would be expected that professional associations inform their members where they are subject to a statutory Code of Conduct.

The ATMS website provided links (accessed via its 'Complaints' tab) to each of the state Codes of Conduct that apply in the four states that (at the time of the mapping) had fully implemented the National Code of Conduct. The ANPA website stated that in addition to its own Code of Ethics, members were expected to comply with the National Code of Conduct for health care workers and provided links to state and territory websites (although not all of these took the user directly to the Code of Conduct and the responsible Commissioner's webpage).

The CMA website provided a tab for 'State Codes of Conduct' under its 'Members area' but this information is behind a paywall (although general information on the National Code of Conduct was publicly accessible). The NHAA provided a link to its submission to government on the National Code of Conduct but no links to the state Codes that apply to members.

Continuing professional development requirements

There was considerable variability across organisations concerning the level of information that was publicly accessible concerning CPD requirements and programs.

The ATMS and NHAA websites provided the most comprehensive suite of materials on CPD and how their respective programs operate, including policies, templates for recording CPE activities, FAQs, and details of programs and symposia.

The ARONAH website contained some limited information – a tab on CPD with information about its expectations and a link to its 'CPD Recognition Application form'.

For the remaining organisations, while it is clear they set requirements for CPD for their members, all or most of the information was contained in member services areas of the websites that were not publicly accessible:

- The ANTA website provided information on its CPD requirements under its FAQs tab. CPE guidelines and a log for entering CPD activities were referenced there but were not publicly accessible (members only).
- The ANPA website listed its CPE program as one of the benefits of membership, however no information was publicly accessible (accessible by members only).
- The CMA website provided a tab for CPE Points (password protected) and general information under its FAQs.

Guidance on COVID-19 related requirements and infection control standards

Using the available search functions, no relevant information on COVID-19 policies was found on the ATMS and CMA websites. The search facility on the NHAA website identified several items on COVID-19 including: COVID-19 safety plan, position statement on COVID-19, COVID-19 update, and position statement on COVID-19 vaccinations (see below). The remaining websites (ANTA, ANPA, and ARONAH) did not provide a search facility. The ANTA website provided a tab for 'COVID-19 Response' with links to communications issued by state and territories.

Only two associations (ANTA and NHAA) had issued policy statements concerning COVID-19 vaccination.

The NHAA website stated:

> *The Naturopaths and Herbalists Association of Australia supports and endorses the evidence-based advice of various expert bodies overseeing the National COVID-19 Vaccination Campaign in Australia [...] NHAA supports COVID-19 vaccination for all healthcare practitioners and believes all health practitioners should be vaccinated for their own protection, and for the protection of others.*

The ANTA website stated:

> *As an Association, we have always taken a pro-choice stance as we strongly believe every individual should assess the risks of any medical intervention against their own personal health, and the advice from their healthcare professional. We trust our members have the ability to consult with their healthcare professional on what is best for them.*

Only ATMS published publicly accessible guidelines for members on infection control. While the document referenced various national infection control standards, it was more than five years old and there have been updates to some standards as a result of the COVID-19 pandemic. ATMS also advised that it provided regular updates to members via electronic direct mail, sometimes weekly.

Guidance on working with children checks

Most organisation websites did not provide publicly accessible information on state and territory working with children check requirements that may apply to members, although CMA provided a tab for this in its 'Members area' (behind a paywall) and some general information under its tab 'How to apply'.

Policy position on registration of the naturopathy profession

All organisations published information indicating their position on whether naturopaths should be registered under the NRAS. All except for ATMS indicated support

for national registration for the naturopathy profession. The ATMS Position Statement on Statutory Government Regulation (2021) states that ATMS considers the current regulatory framework (a combination of voluntary self-regulation by professional associations and regulation by state and territory health complaints commissions) provides adequate protection for the public.[63]

63 See ATMS website: www.atms.com.au/wp-content/uploads/2024/03/ATMS-Position-Statement-Registration-May-2021.pdf

Table 7.6: Information on practice standards published on the websites of organisations

	PROFESSIONAL ASSOCIATIONS					VOLUNTARY REGISTER
Name of organisation	ANPA	ANTA	ATMS	CMA	NHAA	ARONAH
Code of Ethics/Code of Conduct	YES	None found	YES	YES	YES	YES
CPD requirements	YES	YES	YES	YES	YES	YES
CPD policies, forms, approved programs etc	Not found (members only)	Not found (members only)	YES	Not found (members only)	YES	IN PART
Links to state/territory health complaints commissioners	YES	Not found	YES	Not found	Not found	NO
NSW/Qld/SA/Vic Codes of Conduct & prohibition order powers explained	IN PART Links to 2015 reports and state/ territory websites	NO	IN PART Links to state codes of conduct	Not found (behind paywall)	NO Links to NHAA submissions	IN PART
Links to working with children check requirements	NO	NO	NO	YES – See 'How to Apply' tab	NO	NO
Policy position on statutory registration for profession	YES Supports	YES Supports	YES Does not support	YES Supports	YES Supports	YES Supports
Policy position on evidence-based medicine	None found	None found	None found	None found	None found	YES (see competency standards & practice standards)
Infection control guidelines	NO	NO	NO	NO	NO	NO
Policy position on COVID-19 vaccination	None found	Yes 'Pro-choice'	None found	None found	YES	None found
Links to state/territory COVID-19 vaccination requirements for health care workers	NO	YES	NO	NO	NO (NHAA advised this information removed as no longer needed)	NO

7.6 ACCREDITATION OF EDUCATION PROGRAMS

Table 7.7 presents data on the information published on the websites of each of the six organisations about the accreditation of education programs for the purposes of membership.

Three organisations (ARONAH, ATMS, and NHAA) published the accreditation standards against which education programs were assessed for membership purposes. While all organisations published a list of accepted qualifications and programs for membership purposes, only two (ARONAH & NHAA) published a detailed description of the accreditation process including fees charged. ARONAH's Naturopathic Education Accreditation Standards were the most extensive set of standards, published in 2021 following a process of public consultation.

No information could be found on organisation websites concerning the performance of their accreditation functions, such as data on numbers of accreditations completed, the accreditation review cycle, conditions placed on accreditations, or any adverse findings arising from an accreditation.

Table 7.7: Information on accreditation of education programs published on the websites of organisations

	PROFESSIONAL ASSOCIATIONS					VOLUNTARY REGISTER
Name of organisation	ANPA	ANTA	ATMS	CMA	NHAA	ARONAH
Accreditation standards published	NO	NO	YES ATMS Minimum Education Standards	NO	YES	YES
Competency standards	NO	NO	YES	NO	NO (under review – due mid 2022)	YES
Description of accreditation assessment process	NO	IN PART	YES	NO	YES	YES
Online application forms	YES	NO	YES	NO	YES	NO
Schedule of fees for accreditation published	NO	No fees charged	NO	NO	YES	YES
List of accredited or approved providers and programs	YES	YES	YES 'ATMS recognised providers'	NO	YES	YES
Details of conditions on accreditation	NO	NO	NO	NO	NO	NO
Adverse findings/decisions	NO	NO	NO	NO	NO	NO
Data on performance of accreditation functions	NO	NO	NO	NO	NO	NO

7.7 COMPLAINT HANDLING MECHANISMS

In 2005, 13 out of 14 associations reported they had a complaints mechanism, with eight supplying information on their processes (Lin et al., 2005: 170). All dealt with the rights of practitioners and the process of expelling practitioners from membership. However, the Lin Report found a lack of clear process concerning how complaints were submitted by practitioners or the public; how the nominated committee was to deal with the complaints; the rights of complainants; whether committee documents were 'blinded', and whether voting on expulsion was conducted in the context of a general meeting or by a secret ballot. Only six associations had insurance to indemnify board members against legal costs incurred through a complaints process, thus leaving the associations vulnerable to the cost of prolonged or vexatious legal processes.

The Lin Report provided a comparison with complaints mechanisms for the Chinese medicine profession under statutory registration, including the number, nature, and source of complaints, and their outcomes.

Table 7.8 presents data on the information published on the websites of each of the six organisations about the current complaints management functions.

All organisation websites provided general information about their complaints management system, including how to lodge a complaint about a member of the organisation.

While ATMS and NHAA required the completion of a form to lodge a complaint, ARONAH provided no detail but multiple pathways – email, letter, phone call. Only ATMS and NHAA provided a consumer guide to making a complaint and only two organisations (ANPA and ARONAH) provided links to the Health Complaints Commissioner websites in each state and territory.

In accordance with obligations under state Codes of Conduct for unregistered health care workers, only ATMS imposed a specific professional obligation on members to report to the Association (or an appropriate authority) another member who 'has placed or is placing clients at risk of harm' (ATMS Code of Conduct 2019, Clause 2.5). Such issues were also addressed in the ARONAH Code of Conduct (Clause 6.3) but without an explicit obligation to report.

With the exception of ARONAH (in its Chair's Report), no organisation published data on the number or type of complaints received, how they are dealt with, or disciplinary decisions.

Table 7.8: Information on complaints handling and disciplinary functions published on the websites of organisations

	PROFESSIONAL ASSOCIATIONS					VOLUNTARY REGISTER
Name of organisation	ANPA	ANTA	ATMS	CMA	NHAA	ARONAH
General information on complaints handling system	YES	YES	YES	YES	YES	YES
Overview of disciplinary processes (fitness to practice)	YES	Minimal	YES (see Consumer Guidelines)	YES – See 'About CMA'	YES	In part
Information on how to lodge complaint	YES	YES	YES – webpage	YES	YES	YES – multiple avenues
Online lodgement of complaints	NO	YES	YES	NO	YES	YES
Information tailored to consumers about how to make a complaint	YES	YES	YES (Consumer Guidelines for Making a Complaint)	YES	YES	In part
Information for practitioners about professional obligations to report misconduct of other professionals	NO	NO	YES (ATMS Code of Conduct Clause 2.5)	NO	NO	NO
Advice on role of Health Complaints Commissioners' Code of Conduct & prohibition order powers	IN PART (some links to State and Territory Health Complaints Commissioners)	NO	NO	NO	NO	IN PART (explanation of role of Code of Conduct)
Data on performance of complaints handling system	NO	NO	NO	NO	NO	NO
Decisions of disciplinary panels	NO	NO	NO	NO	NO	NO

7.8 ORGANISATION ISSUES AND CONCERNS

The Lin Report identified several issues of concern to associations in 2005. The current study found that many of these issues continue to be of concern to associations.

Regulatory policy

In 2005, the Lin Report reported that the associations did not present a unified voice on the issue of regulation of naturopaths, with associations split on support for or opposition to statutory regulation and views on the effectiveness of self-regulation (Lin et al., 2005: 173).

While the number of professional associations has more than halved since 2004, there is still disagreement on the issue of regulation of naturopaths. Of the six organisations included in this study, five had a stated policy of supporting statutory registration for the naturopathy profession (ANPA, ANTA, ARONAH, CMA, & NHAA) demonstrating a high degree of alignment. The ATMS policy is that the current regulatory framework provides adequate protection for the public.[64]

Access to medicines

In 2005, the Lin Report reported that since the passage of the Therapeutic Goods Act 1989 (Cth), the list of herbs removed from use by naturopaths and herbalists has steadily grown, with substances listed in Appendix C of the Standard for Uniform Scheduling of Medicines and Poisons (SUSMP) (2005:174).[65] These substances are considered to be of sufficient danger to health that use by any practitioner is illegal (See Appendix 3.4 for list). Placing herbs on the SUSMP effectively means their withdrawal from use by naturopaths:

> *The current level of regulatory restraint was seen as an unacceptable restriction on the use of the profession's 'tools of trade'. This also affects consumers who are denied access to an increasing number of therapeutic substances as potentially toxic herbs continue to come under the scrutiny of the TGA (2005: 174).*

64 See the ATMS Position Statement on Statutory Government Regulation. https://www.atms.com.au/wp-content/uploads/2024/03/ATMS-Position-Statement-Registration-May-2021.pdf

65 Note changes to the SUSMP – Appendix C is now empty and the substances previously listed there are now included in Appendix 10 of the SUSMP.

This study found that the situation with respect to access to herbal medicines has not changed, except that the number of herbal substances restricted under the SUSMP has increased. Without statutory registration, there is no mechanism to authorise suitably qualified naturopaths and herbalists to prescribe or dispense these restricted herbal medicines, even if they have the competencies to do so safely.

Education policy

In 2005, there was reportedly no agreement between associations on the minimum standard of education for entry to practice – some segments of the profession were working towards a bachelor's degree as the minimum qualification for entry to practice while others were of the view that the required standard should remain at the vocational level. Having professional entry programs offered at different educational levels was considered a problem (Lin et al., 2005: 175).

The current study finds the situation has shifted, to the extent that five out of six organisations agreed on the minimum qualification standard for entry to the naturopathy & WHM professions. However the required level of education for naturopaths and herbalists continues to be a matter of debate within the profession, an issue that has remained unresolved for at least three decades (Evans 2000: 237-238; McCabe 2008: 169).

While in 2005, no association argued that diploma or advanced diploma education was the most appropriate level of education for entry to practice as a naturopath (Lin et al., 2005: 175), this is not the case today, with one of the six organisations (ATMS) accepting for membership purposes naturopathic qualifications that have not been accredited by either the Tertiary Education Quality and Standards Agency (TEQSA) or a University in the higher education sector or the Australian Skills Quality Authority (ASQA) in the VET sector. These issues are discussed further in Chapters 6 and 10 of this report.

7.9 DISCUSSION

Fragmented representative arrangements

In 2005, the Lin Report identified 17 professional associations, 14 of which responded to the survey. The current study found only five of these associations still in operation.

It is not clear why the number of associations has contracted by more than two thirds over two decades. The causes are likely multi-factorial. Contributing factors may include increased reporting and accountability obligations placed on incorporated associations under changes to state and territory laws, combined with a decline in member incentives to join, for example, due to the loss of private health insurance rebates. It is likely that the expansion in the number of professional associations during the early 1990s did not serve the profession well and associations were unable to attract sufficient members to remain viable.

A characteristic of the professionalisation process observed in many professions is the consolidation of representative arrangements into a single national peak body. This may be what we are seeing in the trajectory of change in representative arrangements for the naturopathy and WHM professions. While further research would be needed to identify causal links, government policies (such as the mechanisms for eligibility for GST exemption and private health insurance rebates, VET sector accreditation, associations incorporation changes) may have influenced this trajectory of change. Arguably the fragmentation of representative arrangements has weakened the professions' voice to governments and compromised the capacity of these professions to influence government policy on matters that affect the interests of members.

With the multiple associations, each vying for members, it is difficult for prospective members to make an informed decision about which association to join and for governments to have confidence that any one association speaks with authority on behalf of the naturopathy and WHM professions. More importantly, efforts to self-regulate have so far failed to produce a single national, consistent and effective system of credentialling and quality assurance for these professions.

The establishment of the ANC is a welcome development – suggesting a maturing of the representative arrangements. However, the lack of agreement on degree level as the entry requirement and whether these professions should be statutorily registered continues to be a barrier to improving liaison and cooperation between professional associations.

Transparency of governance

While some organisations are doing better than others in terms of the range of member services they offer and the breadth and transparency of information publicly available, there is room for improvement. For instance, only one organisation makes its annual reports or Directors' reports publicly available on its website and only one organisation publishes a strategic plan.

It is difficult for the public or prospective members to understand how ARONAH's governance, role and functions differ from the other professional associations – that it has been established to regulate the profession at arms-length from the representative functions of any of the professional associations. An inadequate resource base is likely constraining ARONAH's efforts to achieve its mission.

Member requirements and benefits

Membership of a professional association is voluntary. With the removal of private health insurance rebates for naturopathy treatments, a quasi-regulatory mechanism

that provided an important incentive for practitioners to join an association has been removed.

Every organisation has developed a code of conduct or ethics and requires practitioner members to adhere to this in their practice. Professional indemnity insurance and first aid training are uniform requirements, and every organisation stipulated an annual CPD requirement for full members.

All organisations provided a range of benefits to their members including professional indemnity insurance, practice guidance, CPD programs, and advocacy. Some organisations appear to be more active than others.

Some organisation websites contain information that is misleading as to the benefits provided, particularly eligibility for private health insurance rebates. This is evident with the multi-modality associations. Few organisations provide accurate and up-to-date information for members on matters of concern such as the Federal Government's Natural Therapies Review 2019-20.

Policy and guidance functions

The websites of all organisations contain some policy statements and guidelines for naturopaths about practice issues. However, as reported in 2005, the current study found most websites were light on content, with a limited range of materials.

Only two organisations published standards or guidance for members concerning issues such as professional indemnity insurance, advertising of naturopathic medicines, patient record keeping, privacy, CPD, and recency of practice. While the codes of conduct of some organisations touched on practice issues, no standalone guidelines were found on topics such as evidence-based practice, understanding the limits of practice and referral to medical practitioners, infection prevention and control, management of adverse events, or drug-herb interactions.

On most websites, information provided on COVID-19 was limited and only two organisations provided links to public health orders on government websites (although in some cases this information is hard to find and cannot be found via the search function). Only one association provided guidance to its members on the importance of vaccination for practitioners and patients and the need for practitioners to support public health messaging. One organisation website included material about pandemics and vaccination that appears was not evidence-based. Another stated that it is 'pro-choice' with respect to vaccinations.

There was a lack of transparency on some websites concerning policies and practice guidance, because access to documents was password protected (for members only).

Only one organisation published a quarterly peer-reviewed scholarly journal.

Accreditation of education programs

In 2005, there was significant variation in the minimum education qualification required for credentialling of naturopaths and herbalists for entry to practice. Two decades later, the current study finds that efforts to self-regulate have failed to produce a single national standard for minimum qualifications for entry to practice in the profession. However, all organisations bar one professional association have agreed to a national qualification standard and since 2019 accept for membership only degree qualified practitioners. Only one organisation (ARONAH) publishes its accreditation standards and procedures, against which education providers and qualifying programs are assessed.

Complaint management and disciplinary functions

The three organisations that participated in the survey provided data on complaint handling. This data is presented and analysed in Chapter 3.

For most organisations, there was little publicly accessible information published on websites about the complaint management policies and procedures and how to make a complaint. With no data presented on any organisation website on the performance of the complaint handling and disciplinary functions, there is little transparency or accountability in the exercise of these functions. The lack of documentation also suggests there is little active monitoring of the performance of this function.

For instance, few organisations had user-friendly information to encourage patients to take that initial step of lodging a complaint and no organisation makes clear that its staff can assist a prospective complainant to fill in the form (where there is one). There was little coherent explanatory material on any of the websites about the nature of the relationship between the organisation's complaint management functions and the role of the state and territory health complaints commissioners who conciliate consumer complaints and investigating breaches of a statutory code of conduct for unregistered health care workers (in the six states/territories where a statutory code has been enacted). Only one organisation alerts members in its own Code of Conduct about their obligation to report a fellow practitioner who is placing patients at risk of harm.

Advocacy functions

The websites of all organisations showed evidence of advocacy activities on behalf of the profession, with copies of submissions to government posted.

While some organisations appeared to be more active than others, materials generally were not well organised or presented and there was little if any explanatory material to provide context or to educate members on policy issues.

Views on statutory registration for the naturopathy and WHM professions

A virtual townhall session sponsored by NHAA in 2023 suggests there is widespread misinformation amongst naturopaths and herbalists about how statutory registration might impact the professions. For instance, concerns were expressed about potential loss of control of professional practice standards and that those without recent degree level qualifications might be required to upgrade their qualifications or else have their right to practise removed altogether (ANC verbal communication, November 2023).

7.10 CONCLUSIONS

The role of naturopathy and WHM professional associations includes the setting of standards for the profession, credentialling practitioners, accrediting programs of study, protecting and advocating for the profession, and protecting the public (through self-regulation). As reported in 2005, this study reveals limitations in the ability of associations to carry out these important functions.

The continued fragmentation of representative arrangements for the naturopathy/WHM professions, the number of associations, and the lack of consensus on entry to practice qualifications, education and occupational regulation are compromising the capacity of these organisations to discharge core representative and regulatory functions. By spreading members and resources across multiple associations, the capacity of every association to deliver a full range of benefits to members and engage in advocacy efforts on behalf of the profession is compromised. Most websites are light on content, particularly with respect to the policy/guidance and advocacy functions.

Complaints are an important source of data for quality improvement. There is little transparency in the complaint management processes of most organisations, and little evidence that members of the public are being encouraged or assisted to lodge complaints. It is imperative that associations strengthen this area of their operations, particularly to develop stronger links with health complaints commissioners in each state and territory, provide more consumer-friendly information on the code of conduct and prohibition order powers that apply in six jurisdictions, and provide a consistent data set on complaints management, to enable better monitoring of risks and harms associated with practice.

The absence of effective regulation has allowed standards to evolve in an ad hoc manner, overseen by multiple associations with various positions regarding regulation, all vying for members. While five out of the six organisations have set bachelor's degree as the minimum qualification for membership, the largest professional association continues to accept programs at less than degree level that have no government accreditation. This undermines the efforts of the other associations to enforce a minimum entry to practice standard at bachelor's degree level.

It is difficult for self-regulation to be effective, transparent, and accountable while the regulatory structure is not independent of the professional associations (Expert Committee 2000). While the establishment of ARONAH has gone some way to providing a self-regulatory framework that is independent from the professional representative functions, it is hampered by lack of resourcing due to its small membership base and lack of government incentives to encourage naturopaths and herbalists to join.

As in 2005, the solution remains consolidation – fewer, larger, better-resourced associations would benefit these professions and better protect service users.

8
INSTITUTIONAL RECOGNITION OF AND SUPPORT FOR NATUROPATHY AND WESTERN HERBAL MEDICINE PRACTICE

Anne-Louise Carlton

8.1 INTRODUCTION

Researchers have debated for over a century what constitutes a 'profession', whether occupations go through an identifiable sequence of stages in their 'professionalisation journey' or whether there are stages at all (Jones 1991: vii). For instance, Wilensky's 'natural history of professionalisation' postulated the following steps:

- the emergence of a full-time occupation
- the establishment of training schools
- the founding of a professional association (or consolidation of smaller bodies into a single peak body)
- the adoption of formal standards of practice and codes of conduct, and
- increasing political agitation directed towards protection of the profession by law and carving out an exclusive scope of practice (Wilensky 1964: 142-46)

Regardless of what definition of 'profession' is adopted, considerable diversity is evident in the extent to which health occupations have consolidated and 'institutionalised' their practice and the power and influence these institutions exercise within the health system and beyond. This is evidenced by the range, scope, and strength of voice of the institutions that reproduce and represent the interests of the various health professions, the extent of recognition by other institutions such as governments and insurers, and the benefits conferred on members.

In 2005, Lin & colleagues provided a snapshot not only of the institutions that represent naturopaths but also the extent of institutional recognition of the practice of naturopathy and WHM by other civil society institutions (2005: 183-215).

The purpose of this chapter is to update this picture by examining the broader institutional arrangements that intersect with and shape the practice of naturopathy and WHM in Australia, in particular, the extent to which the institutions of government and civil society recognise and engage with naturopaths and herbalists and their practice.

Presented are the findings of enquiries made of a variety of institutions both government and non-government, including:

- health insurers providers (public and private), including:
  - Medicare Australia
  - State and territory workers compensation and traffic accident insurers
  - Veterans Affairs
  - Private health insurers and their representative bodies
- professional indemnity insurers
- the Australian Taxation Office (ATO)
- statutory regulators including:
  - National Boards for the regulated health professions
  - Australian Government Therapeutic Goods Administration
  - State and Territory health complaints entities
- higher education regulators
- research institutions including the National Health and Medical Research Council

- hospitals (public and private) and community based public health services, and their respective peak bodies
- professional associations and other interest groups that represent health professions that naturopaths may collaborate with.

The aim is to better understand where the naturopathy and WHM professions sit within the health care system and the institutional linkages, relationships, partnerships, and collaborations that operate. This analysis supplements and extends the findings from Chapter 7 on naturopathic/WHM organisations.

8.2 METHODOLOGY

Types of institution included in this study were identified based on those surveyed and reported in the Lin Report (2005), supplemented by knowledge held by members of the ANC Research Reference Group.

A range of information was gathered from websites, including policies, plans, reports, committees of relevance to naturopathy and naturopaths. If further data collection was considered necessary, institutions were contacted, initially by telephone and email, with a follow-up letter requesting information on the policies of the organisation with respect to naturopathy and naturopaths and the nature of the engagement the institution has with naturopaths (if any).

8.3 HEALTH INSURANCE PROVIDERS

In 2005, Lin & colleagues reported the results of a survey of organisations involved in the reimbursement of clients or patients for costs incurred in accessing allied health services. In general terms, they found that private health insurers demonstrated the highest degree of engagement with the naturopathy profession, with other bodies regulated and/or funded by government having little or no engagement (2005: 184).

Private health insurance funds

In 2005, a total of 32 private health funds that responded to the survey (either directly or via their industry body) were providing reimbursement for CAM services including naturopathy. Fourteen funds reported they had criteria for formal recognition of naturopaths as providers of services and provided partial rebates for consultation fees only. None reported providing rebates for herbal medicine or other remedies, supplements, or treatments provided by naturopaths (Lin et al., 2005: 185)

2024 presents a very different picture. Since publication of the Lin Report, the ability of private health insurers to reimburse clients or patients for the costs incurred in accessing the services of naturopaths has been withdrawn because of changes in Australian Government policy and regulation, specifically, changes to the Private Health Insurance Rules (Cth) – see Textbox 8.1.

Textbox 8.1: Changes to the Australian Government's Private Health Insurance Rules affecting the naturopathy and WHM professions

In 2018, the Australian Government decided to change the Private Health Insurance Rules to prevent private health insurers from offering rebates for consultations by recognised providers of naturopathic medicine. From 1 April 2019, 16 natural therapies were excluded from private health insurance cover, including the profession of naturopathy.

This decision by the Australian Government means that private health funds cannot currently offer cover to their members for any services provided by a naturopath. The decision was made following a 2015 review of the Australian Government Rebate on Private Health Insurance. Following significant critique of the 2015 review used as the basis for this decision, on 7 April 2019, a further review was announced by the Federal Minister for Health (the 2019-20 Review) and is still underway.

The effect of this decision has been to remove the most significant incentive that encouraged those entering practise as a naturopath to put the effort into obtaining an acceptable education qualification. It also removed the incentive for practitioners to join a professional association, thereby reducing the effectiveness of the voluntary certification schemes operated by these associations, and the degree of accountability and oversight exercised by the associations for maintaining professional standards, such as enforcing mandatory continuing professional development, first aid training, and professional indemnity insurance cover.

Since 1 April 2019, 16 natural therapies including naturopathy and Western herbalism have been excluded from the definition of private health insurance general treatment and no longer receive the private health insurance rebate as part of a general treatment policy. Rules were made to exclude naturopathy and Western herbalism from the definition of general treatment under section 121-10 of the *Private Health Insurance Act 2007*. Since that date, insurers are prevented from offering benefits for these therapies as part of a complying health insurance policy. The Australian Government Department of Health and Aged Care is undertaking a review of this policy decision (see the Natural Therapies Review 2019-20).[66]

Chapters 7 and 10 address the implications of these changes for the naturopathy and WHM professions, given the co-regulatory functions carried out by health funds. Workers' compensation insurers

66 See the Australian Government Department of Health and Aged Care webpage on the Natural Therapies Review.

The Lin Report surveyed all state and territory workers compensation insurers. In 2005 the services of naturopaths were allowable under some workers compensation schemes and not others. There were also several schemes where naturopathic services might be allowable if interpreted as 'reasonable medical therapies', on referral from a medical practitioner (2005: 207).

Since then, the Heads of Workers Compensation Authorities of Australia and New Zealand[67] have signed up to a nationally consistent approval framework for providers of rehabilitation services for injured workers. These arrangements are set out in a document titled *Guide: Nationally consistent approval framework for workplace rehabilitation providers* (2015). Despite this national agreement, there continues to be variation in the processes for approval of allied health practitioners to provide 'injury management plans' in the context of 'reasonable and necessary services' to support a worker's return to work, and the types of allied health practitioner who are eligible to provide such services.

Appendix 8.1 lists the workers compensation legislation and regulators in each state and territory and the reimbursement arrangements for naturopaths where applicable.

Only in Victoria is there specific provision for Victorian based naturopaths to be approved as allied health service providers for patients located within Victoria. In NSW, there is provision for conditional approval of complementary therapies for the treatment of work-related dust diseases (although naturopathy is not specifically mentioned). In Western Australia, there appears to be scope for an employer's insurer to reimburse the costs of treatment provided by a 'non-approved health provider' such as a naturopath. There may be similar flexibility in other states for non-approved providers to contribute to injury management plans, except for Queensland where the website states that services provided by naturopaths are not covered.

Other third-party insurers

The Lin Report surveyed other third-party compensation schemes such as the Health Insurance Commission (Medicare), the Department of Veterans Affairs, state and territory traffic accident compensation agencies and the Commonwealth Rehabilitation Service to establish whether any of these schemes reimburse to patients the cost of naturopathy services and if so, under what conditions. The Lin Report found that none of these insurers reimburse patients/clients for services provided by naturopaths. The Report noted that chiropractors and osteopaths are recognised providers.

While there have been significant changes to the machinery of government (with some agencies abolished and new ones established), the situation in 2024 is little different from 2005 with respect to reimbursement arrangements for naturopathic services, with the exception of the National Disability Insurance Scheme (NDIS).

Health Insurance Commission – unlike the registered professions of chiropractic and osteopathy and some non-registered health professions such as exercise physiologists, naturopaths are not eligible to register to provide allied health services reimbursed under Medicare programs such as the Chronic Disease Management Program for people with chronic conditions and complex care needs who are managed by GPs.

National Disability Insurance Scheme – the Commonwealth Rehabilitation Service (CRS) was abolished in 2015 with the establishment of the National Disability Insurance Scheme (NDIS) and a network Disability Employment Services. Unlike other allied health services, naturopathic services are not specifically included as services and supports funded under the NDIS. However, there is some anecdotal evidence to suggest that some naturopaths are providing NDIS funded services. This is understood to be occurring for self-managed or plan managed NDIS participants, under the NDIS plan category of 'Improved Health and Wellbeing' where research or evidence is presented to show that the treatments will be of benefit to the NDIS participant.

ComCare – ComCare is the national authority for work health and safety, and workers' compensation established under the Safety, Rehabilitation and Compensation Act 1988 (Cth). Allied health services may be provided as part of a treatment plan to support an employee's return to work, under the direction of a GP or medical specialist. The allied health services may include counselling, exercise therapy, massage therapy, osteopathy, pharmacy, physiotherapy, and psychology. Naturopathic services are not eligible for inclusion in treatment plans.

Department of Veterans Affairs – unlike other registered and non-registered health professions including chiropractors and osteopaths, naturopaths are not included in the list of allied health providers that are eligible to provide funded services to veterans.

Transport accident compensation agencies – Appendix 8.2 provides an overview of the arrangements for reimbursement under transport accident compensation schemes in states and territories. There is no evidence on the websites of these agencies to suggest that naturopaths may be registered or approved as providers of allied health services for persons injured in motor vehicle accidents, although in some jurisdictions there may be scope for negotiation with the insurer about what services are 'reasonable and necessary' to support recovery.

67 The Heads of Workers' Compensation Authorities (HWCA) is a high-level forum for discussing, promoting, and implementing best practice workers compensation arrangements. HWCA is comprised of the Chief Executives (or their representatives) of the peak bodies responsible for the regulation of workers compensation in Australia and New Zealand. This includes Australia's ten workers' compensation authorities (six states, two territories and two Australian Government) and the New Zealand Accident Compensation Corporation. See the HWCA website: https://www.sira.nsw.gov.au/corporate-information/heads-of-workers-compensation-authorities

8.4 PROFESSIONAL INDEMNITY INSURERS

In 2005, Lin & colleagues reported the results of a survey of professional indemnity insurance (PII) providers, finding six companies that reported they provided PII to naturopaths and herbalists. The report presented data on:

- the availability of PII for naturopaths including via group schemes organised by professional associations
- the cost of annual premiums and the minimum level of cover provided
- the methods used by insurers to assess the eligibility of naturopaths for cover including the qualification requirements
- any claims information

Twenty years later, in 2024, little has changed. Most of the peak professional associations that represent naturopaths and herbalists negotiate arrangements for preferential group insurance rates for members, via various insurance brokers/providers, with current benchmarks at $10 million for public liability and $2 million for professional indemnity. Practitioners may also source insurance independently of an association group program.

One development is worth noting - the National Code of Conduct for unregistered health care workers as it applies in six jurisdictions (ACT, NSW, Queensland, South Australia, Victoria and Western Australia) requires non-registered health practitioners to have in place appropriate indemnity insurance arrangements for their practice.[68] However, there is no mechanism for monitoring compliance with this requirement or whether the level and type of insurance held is appropriate, unless the practitioner is the subject of a complaint to the responsible state health complaints commissioner.

8.5 THE AUSTRALIAN TAXATION OFFICE (ATO)

In 2005, Lin & colleagues outlined the Goods and Services Tax (GST) arrangements that applied in 2005 to the services and medicines provided by naturopaths. At that time, naturopaths were deemed to be 'recognised professionals' under the legislation A new tax system (goods and services tax) Act 1999 and were exempt from the requirement to charge GST on their consultation fees but were required to charge GST on any medicines or treatments provided. Eligibility for 'recognised professional' status was tied to full membership of an association that had been formally assessed as meeting the ATO's definition of a 'professional association' (2005: 194).

Twenty years later, the situation has not changed. Naturopaths who are members of an association that meets the ATO's requirements continue to be deemed to be 'recognised professionals' under the GST legislation and are exempt from the requirement to charge GST on consultation fees.

8.6 NATIONAL BOARDS FOR REGULATED HEALTH PROFESSIONS

In 2005, Lin & colleagues reported on information sought from state and territory health practitioner registration boards on whether they had published any policies or position statements for their respective registrants on the use of CAM. The websites of medical, nursing, and pharmacy registration boards were accessed and a number of policies, position statements, and guidelines were identified and analysed. They concluded:

> ***State medical boards recognise the increasing importance of CAM and the existence of dual usage by patients of mainstream therapies and CAM therapies. There is support for the use of CAM in medical practice providing there is sufficient high quality research evidence for any therapy used. Where this is limited or non-existent, the medical practitioner must at least be able to provide evidence that the treatment is safe and the patient will not be harmed by withholding conventional therapy. All patients should be asked about their use of CAM to determine if such use poses any risks, particularly the risk of interaction with pharmaceutical drugs (2005: 197).***

In 2010 the institutional arrangements for regulation of the health professions were reformed with the abolition of state and territory registration boards and the establishment of the NRAS (see **Chapter 10** for further detail). Under the Health Practitioner Regulation National Law as in force in each State and Territory, there are now 15 National Boards that regulate 16 health professions and a further profession (audiology) being assessed for inclusion in the scheme.[69] The National Boards are supported by a single national agency, Ahpra. With these reforms, the position statements and guidelines on use of CAM that were issued prior to 2010 by state and territory boards have lapsed.

In 2023, a search of the websites of Ahpra and the 15 National Boards revealed only one document related to complementary therapies and naturopaths, a 2019 publication of the Medical Board of Australia (MBA) titled Public consultation paper: complementary and unconventional medicine and emerging treatments.

According to the MBA website, over 13,000 submissions were received, many of which are published on the MBA/Ahpra website. In its submission, the Australasian

68 See for example Clause 16 of the National Code of Conduct for Health Care Workers (Queensland).
69 See Queensland Health website: https://www.health.qld.gov.au/clinical-practice/engagement/clinical-engagement-projects-and-consultations/audiology-regulatory-impact-statement

Integrative Medicine Association (AIMA) raised concerns, urging the MBA not to publish separate guidance on use of complementary and unconventional medicine and instead, to rely on the general guidance available in the Board's code of practice.[70] The AIMA submission argued that:

> *... if adopted, these guidelines and the associated discussion paper/rationale would create a two-tiered system which could threaten the practice of integrative medicine and lead to integrative medicine doctors being unfairly and unreasonably targeted (AIMA 2019).*

In 2021, the MBA announced its decision not to issue guidelines on 'complementary and unconventional medicine and emerging treatments' and instead, to continue to rely on the existing standards framework set out in its publication Good medical practice: a code of conduct for doctors in Australia. The MBA stated:

> *The feedback from the consultation made it clear that there was no simple equation linking areas of practice with risk to patients, and that high-risk practice is not confined to one area of practice.*
>
> *We recognise that the solution we had proposed did not match the problem we were trying to solve. Also, the labels we used – complementary and unconventional medicine and emerging treatments – were not helpful in defining the level of risk posed to patients.*
>
> *The persisting issue of patients being offered high risk treatments that do not have an evidence base of safety and efficacy is not limited to complementary and unconventional medicine and emerging treatments. As well, the problem of vulnerable patients not being provided with the information they would need to give genuinely informed consent is not limited to a specific area of practice.*
>
> *The Board will continue to refine its risk-based regulatory approach, so that regulatory safeguards match risk to patients across all areas of practice. This work will not be limited to specific areas of practice and will be developed over time (MBA 2021).*[71]

8.7 EDUCATION AND TRAINING REGULATORS

The Lin Report outlined the institutional arrangements under which education programs for entry to practice as a naturopath were regulated and accredited in 2005. The Report described the respective roles and responsibilities of:

- Universities responsible for self-accrediting bachelor's degree programs
- state and territory government offices of higher education that accredited bachelor's degree programs provided by private colleges, and
- the Australian Government Department of Education, Science and Training (DEST) responsible for oversight of programs delivered by Registered Training Organisations (RTOs) under the Health Training Package (HTP) in the Vocational Education and Training Sector (VET sector).

In 2024, this division of responsibilities has changed, principally because of withdrawal of the Australian Skills Quality Authority (ASQA) from its previous role in assuring the quality of programs that train naturopaths.

Australian Skills Quality Authority (ASQA)

ASQA is the national regulator for Australia's VET sector. Prior to 2018, naturopathy training programs were included in the Health Training Package (HTP) and delivered by Registered Training Organisations (RTOs). ASQA had responsibility for accrediting and assuring the quality of these programs and monitoring the compliance of RTOs with the HTP standards.

Twenty years later, in 2024, this is no longer the case. Following a review of the Complementary & Alternative Health (CAH) qualifications in the Health Training Package (HLT07), the Community Services & Health Industry Skills Council (CSHISC) deemed the minimum level of qualification for the naturopathy profession was better aligned to a bachelor's degree – see Textbox 8.2.

70 See the AIMA submission.
71 See the Medical Board of Australia's statement.

Textbox 8.2: Advice dated July 2014 from CS&HISC on changes to remove naturopathic and WHM qualifications from the Health Training Package

July 2014 Update: Advanced Diplomas of Homeopathy, Naturopathy, Nutritional Medicine and Western Herbal Medicine to be aligned at Bachelor degree level.

All Complementary & Alternative Health (CAH) qualifications in the Health Training Package (HLT07) are currently under review. As part of the review, content is being updated and improved, both to better meet industry needs and to comply with the new national Standards for Training Packages. An Industry Reference Group (IRG) comprising representatives from all CAH modalities oversees this work, and there is also a smaller Subject Matter Expert Group (SMEG) for each modality.

In March 2014, Subject Matter Expert Groups recommended that the Advanced Diplomas of Homeopathy, Naturopathy, Nutritional Medicine and Western Herbal Medicine should be aligned at bachelor's degree level, and therefore be removed from the Training Package. The Complementary & Alternative Health Industry Reference Group agreed to accept these recommendations in May 2014. It also confirmed and agreed to the historical and future process surrounding this re-alignment of qualifications.... The current timeframe for removal of the qualifications from the Training Package is December 2015, and students enrolled before that time will not be affected by the change. CS&HISC is not involved in professional association recognition of qualifications, and those associations would manage any transition arrangements. ***Source****: Community Services and Health Industry Skills Council (2014).*

As a consequence, in 2015, the naturopathy and WHM Advanced Diplomas in the Health Training Package were put into 'teachout' mode with a final completion date of no later than 31 December 2018. The effect was to remove education programs for the naturopathy profession from the jurisdiction of ASQA and the VET sector, placing responsibility for accrediting providers and assuring the quality of programs of study with TEQSA, in the higher education sector.

Tertiary Education Quality and Standards Agency (TEQSA)

Under the Tertiary Education Quality and Standards Agency Act 2011 (the TEQSA Act), TEQSA is established to register and regulate entities as higher education providers and accredit their programs of study. Higher education awards consist of qualifications at Australian Qualifications Framework (AQF) levels 5-10, that is, diplomas, advanced diplomas, bachelor's degrees through to doctoral degrees. All registered higher education providers are listed in the TEQSA National Register.

The TEQSA website states that:

> ***Entities that advertise a higher education award when they are not registered with TEQSA undermine Australia's higher education system because the quality has not been assured by TEQSA. These entities can also have detrimental impacts on students who unwittingly enrol and undertake programs, with the expectation of receiving a recognised higher education award at completion (TEQSA 2023).***[72]

TEQSA refers to these entities as 'unregistered entities' and provides an avenue for complaints about such unregistered providers. It also publishes warnings and advice about the actions a student may take if they believe they have been misled by one of these entities.

There continues to be provisions for Registered Institutes of Higher Education to apply for authority to self-accredit one or more of the programs of study they deliver. The authority to self-accredit programs may be granted for all current and future programs, or for specific programs and fields of education. Two Universities (Torrens University and Southern Cross University) are accredited by TEQSA to offer self-accredited bachelor's or higher degree naturopathy programs.

All providers (whether they self-accredit their programs or not) are accountable for meeting the Higher Education Standards Framework (Threshold Standards) 2021 and ensuring throughout the development, approval, delivery and discontinuance of a program of study that the HES Framework is appropriately applied.[73]

National research institutions

In 2005, Lin & colleagues presented data on the involvement of various national research funding bodies in funding and undertaking research related to naturopathy practice at that time. These institutions included the National Health and Medical Research Council (NHMRC) and the Australian Research Council (ARC) (2005: 199-201). The Report also:

- compared the level of allocation of funds for naturopathy research in Australia with funding for CAM research in the United States under the National Centre for Complementary and Alternative Medicine (NCCAM), and
- outlined recommendations made by the Australian Government's Expert Committee on Complementary Medicines in the Health System and the Government Response to these recommendations (2005: 201-02).

72 See the TEQSA website.
73 See the TEQSA website.

Twenty years later, in 2024, research capability in naturopathy and WHM appears to have grown, with at least three new university affiliated research institutes established, dedicated to complementary medicine research (at Southern Cross University, University of Technology Sydney, and Western Sydney University), with one dedicated to naturopathy research (Southern Cross University). Table 8.1 provides details of these institutes, their objectives, and mission. Naturopathy related research is also being undertaken at other institutions, for example the Centre for Healthy Futures at Torrens University.[74]

TABLE 8.1: Australian research institutes established to conduct complementary therapies research

Name	Sponsoring institution	Year commenced	Description	Mission
NICM Health Research Institute (NICM HRI)	Western Sydney University	2007	Provides leadership and support for strategically directed research into complementary medicine and helps translate evidence into clinical practice and relevant policy to benefit the health of all Australians	
Australian Research Consortium in Complementary and Integrative Medicine (ARCCIM)	University of Technology Sydney (UTS)	2012	ARCCIM provides global leadership in subjecting traditional, complementary and integrative medicine (TCIM) to critical, rigorous, non-partisan public health investigation, exploration and evaluation to help inform safe, effective health care and improve health and wellbeing for all.	To subject TCIM practice and use to rigorous research methods and critical perspectives in order to provide a broad evidence-base for patient care and health policy. To provide national and international leadership by informing world best practice and policy for TCIM use and practice within health care systems. To increase the depth and breadth of research capacity in relation to critical trans-disciplinary TCIM enquiry amongst both researchers and practitioners. To help guide and advance curriculum, teaching and learning developments around the critical public health of TCIM.
National Centre for Naturopathic Medicine (NCNM)	Southern Cross University	2020	We are dedicated to improving the health and wellbeing of individuals and communities in Australia and around the globe by conducting rigorous, innovative, and internationally significant research. The NCNM brings together a vast array of expertise with our team of internationally-recognised scholars. Our faculty are leaders in their disciplines, which forms a multi-disciplinary approach to delivering research with impact. The Centre focuses on four keys areas of research, all approached with a translational outcome in mind. These key areas are natural drug discovery and development; non-pharmacological interventions; integrative models of care; and traditional knowledge.	

National Health & Medical Research Council and Australian Research Council

The NHMRC Annual Report 2021-22 reported that in 2021-22, $971.1 million in new grants were awarded, with over 5,000 grant applications received and 715 grants awarded. No information was found in the Annual Report to indicate that funds were awarded for research on naturopathy. A search of the NHMRC website located information on the role of the NHMRC in assisting the Australian Government Department of Health by commissioning evidence evaluations for complementary therapies. The website states:

To help Australians make informed decisions about their health care, we support research into complementary medicine and publish information about the effectiveness of various treatments.

16 natural therapies, including naturopathy were excluded from private health insurance rebates commencing 1 April 2019, following the 2014-15 review of Australian Government Rebate on Natural Therapies for Private Health Insurance (2014-15 Review).

NHMRC assisted the Department of Health with

74 See https://www.torrens.edu.au/research/research-institutes/chef

the 2014–15 Review by commissioning evidence evaluations for the therapies and assessing submitted evidence.

NHMRC has established a Natural Therapies Working Committee to advise on these evidence evaluations.

NHMRC has commissioned independent evidence reviewers to prepare research protocols and conduct the evidence evaluations for each of the 16 therapies under review.

Only one naturopathy related document was found – a research protocol for a systematic review that is to be undertaken by researchers commissioned by the NHMRC. The research protocol, published in Prospero (the International prospective register of systematic reviews) states that the main objective of the systematic review is 'to assess the effectiveness of whole system, multi-modal or single modal interventions delivered in the context of naturopathic practice for preventing, managing, treating and/ or delaying progression of health conditions in people with a clinical condition, pre-clinical condition or at risk of illness or injury'.[75] The website indicates that a second research protocol is yet to be published, for a commissioned systematic review of the research literature on *Selected nutritional supplements prescribed in the context of naturopathic practice*.

These studies are associated with the 2020-21 Review of Australian Government Rebate on Natural Therapies for Private Health Insurance (see section 8.3).

In addition, at least four naturopathy/herbal medicine researchers have been successful in obtaining research grants from either the NHMRC or ARC.[76]

8.8 NATUROPATHIC PRACTICE IN THE HOSPITAL SYSTEM

In 2005, Lin & colleagues found that peak bodies that represent public and private hospitals had no published position on patient use of CAM (2005: 203).

Twenty years later, in 2024, a search of the websites of the Australian Healthcare & Hospitals Association (AHHA) (the peak body that represents public hospitals) and the Australian Private Hospitals Association (APHA) (the peak body that represents private hospitals) again found no policy or position statement on patient use of naturopathy or T&CM in general.

A reference to the AHHA's position on complementary medicine was found in its submission from December 2015 to the Australian Government's Review of Private Health Insurance Rebates.[77] In that submission, the AHHA advocated abolition of, or better targeting of private health insurance rebates, arguing that any application of the rebate to general treatment cover should only apply to policies covering only safe and effective evidence-based treatments known to maintain and improve the health of consumers (AHHA 2015: 7). The submission further stated:

Health treatments and procedures such as complementary and alternative do not have a reliable evidence base that supports their effectiveness for treating health conditions.

A March 2015 paper by the National Health and Medical Research Council stated people may be putting their health at risk if they reject or delay safe and effective evidence-based medical treatments for homeopathy treatments, and the Commonwealth has stated, 'most alternate therapies have not been assessed for efficacy or safety. Some have been studied and found to be harmful or ineffective'

The Natural Therapies Review Advisory Committee has also recently provided its report to Government in which it stated that, 'clear evidence has not been found' of the clinical effectiveness of natural therapy services (AHHA 2015: 7).

No documents on naturopathy or CAM were found on the website of the APHA – there was no general search facility and submissions made by the APHA dated back to 2018 only and did not make any reference to the Australian Government's review of private health insurance rebates.

In 2005, in the absence of position statements from peak bodies, the development of hospital policies and guidelines was largely left to individual hospitals and was therefore somewhat haphazard (Lin et al., 2005: 203). Lin & colleagues cited several hospital policies, some of which could not be located via search of the websites of these organisations.

Twenty years later, in 2024, more hospitals and peak bodies have published position statements and policies on the use of complementary therapies.

For instance, the Council of Australian Therapeutic Advisory Groups has issued a *Position statement for the use of complementary and alternative medicines*.[78] The statement covers three main points:

- Information, communication, and documentation of a patient's use of any CAM are integral to their overall clinical management.
- Health professionals should apply an evidence-based approach when considering the continuation of a CAM.
- Minimise risk when CAM therapy is continued without the treating team's consent (CATAG 2022: 1-3).

75 See the PROSPERO research protocol.
76 See Australian Research Council - Dr Amie Steel, NHMRC Early Career Fellowship - Associate Professor Jane Frawley, NHMRC Grants
77 Data - Dr Jonathan Wardle, NICM Health Research Institute – Professor Jerome Sarris.
78 Established in 2005, the Council of Australian Therapeutic Advisory Groups (CATAG) is the peak national advisory body, a collaborative of nine Australian state and territory therapeutic or medicines advisory groups. Its purpose is to support Quality Use of Medicines (QAM) in the acute care sector, within the framework of the National Medicines Policy. See CATAG Position Statement.

Some hospitals have referenced this position statement when framing their local policies. See for example, the Sydney Children's Hospitals Network's policy and procedure *Complementary and Alternative Medicine (CAM) use at SCHN*[79] and the South Australia Health's *Complementary and Alternative Medicines Policy Guidelines* (2017).[80]

The Royal Children's Hospital Melbourne website provides advice titled *Use of complementary (natural) medicines in hospital*. The webpage, updated in 2018, states:

- Different medicines, including complementary medicines, can sometimes react badly with each other and cause unexpected problems.
- When your child is admitted to hospital, tell staff about all medicines your child has been taking, including complementary medicines.
- Tell staff if you want to keep giving complementary medicines to your child in hospital. They will advise you if it is safe for your child to keep taking the medicine.[81]

There is also some evidence that naturopathy is being integrated into public and private hospital services. Examples include:

- the Integrative Cardiac Wellness Program at The Alfred Hospital in Melbourne[82]
- Monash IVF[83]

Victorian Government Department of Health – Better Health Channel

The website of the Victorian Department of Health Better Health Channel (a website with information aimed to help people better understand their health) provides a range of materials for consumers on complementary therapies, including naturopathy. The information on naturopathy describes the range of services provided by naturopaths and encourages consumers to search for a qualified naturopath through a link to the Australian Register of Naturopaths and Herbalists.[84]

8.9 MAINSTREAM PROFESSIONAL ASSOCIATIONS

Public Health Association of Australia

The Public Health Association of Australia has issued several public statements about the need to better regulate naturopaths (PHAA 2015; 2019).

> *"Naturopaths are currently one of Australia's largest unregistered professions, with approximately one in ten Australians using their services… Every government report since 2000 looking into the regulatory requirements of naturopaths has said the same thing, the risks associated with this profession are significant enough to warrant registration" according to Michael Moore, CEO of the Public Health Association of Australia. "It's time to take these reports seriously and look at actually regulating naturopaths…The government needs to extend regulation to new professions when required. Regulating naturopaths is an obvious start" (PHAA 2015; Croakey Health Media, 2015).*

Medical professional bodies – AMA, RACGP, and AIMA

The Australian Medical Association (AMA) website includes some materials on CAM in general and naturopathy in particular. This includes the AMA position statement – Complementary medicine 2018, which includes positions on research, funding, use of complementary medicines by medical practitioners, consumers, and regulation of medicines and practitioners. The emphasis of the statement is on evidence-based practice and research:

> *The AMA recognises that evidence-based aspects of complementary medicine can be part of patient care by a medical practitioner.*
>
> *There is limited efficacy evidence regarding most complementary medicine and some have the potential to cause adverse reactions or interact with conventional medicine. Unproven complementary medicines and therapies can also pose a risk to patient health either directly through misuse or indirectly if a patient defers seeking medical advice.*
>
> *Consumer investment in unproven medicines and therapies also risks patients being unable to afford necessary, evidence-based treatment when there are out-of-pocket costs.*
>
> *Evidence-based, scientific research in the form of randomised controlled trials is required to validate complementary medicines and therapies for efficacy, safety, quality, and cost-effectiveness so that practitioners and consumers can evaluate the potential benefits and any adverse effects* (AMA 2018: 1).

The statement also stresses the need for 'appropriate regulation of complementary medicine practitioners':

> *Regulations should ensure complementary medicine practitioners cannot claim expertise beyond their scope of practice.*
>
> *Complementary medicine practitioners should not claim to be able to make a diagnosis of illness for people that the medical profession does not believe are suffering from a medical condition* (AMA 2018: 3).

With respect to registered health practitioners the statement reads:

79 Complementary and Alternative Medicine (CAM) Use at SCHN
80 See SA Health Complementary and Alternative Medicines Policy Guideline 2017
81 See RCH website.
82 See www.alfredhealth.org.au/the-alfred/services/hp/integrative-cardiac-wellness-group
83 See https://monashivf.com/services/support/natural-and-complementary-therapies/
84 See Victorian Government Better Health Channel.

> *Recognition of health disciplines through the process of State or Territory registration should be dependent on:*
>
> *(a) the discipline being supported by accepted scientific evidence of safety and efficacy;*
>
> *(b) registrants completing an approved course of training at an accredited institution.*
>
> *Registered health practitioners must not depart from the scope of practice regulated by the relevant registration board (AMA 2018: 3).*

With respect to non-registered health and complementary medicine practitioners:

> *There must be effective regulation of health and complementary medicine practitioners for whom there is no state-based registration arrangement.*
>
> *The AMA supports the National Code of Conduct for Health Care Workers approved by the Council of Australian Governments and enacted in law in each State and Territory.*
>
> *The National Code requires non-registered health and complementary medicine practitioners to observe a code of practice, including that they must not provide care that is outside their experience or training. It provides a mechanism to apply sanctions for breaching the code, including a ban on practice, as well as mutual recognition of prohibition orders across Australia.*
>
> *The AMA also supports the establishment of a national public register of non-registered health and complementary medicine practitioners who are the subject of a banning order in their State or Territory to assist employers and the general public identify unethical and incompetent practitioners (AMA 2018: 3).*

The website states that in February 2011, the AMA responded to an invitation from the Australian Register of Naturopaths and Herbalists to comment on the development of practice, registration, and accreditation standards for naturopathy and WHM in Australia. While the full submission is behind a paywall, the AMA advised that *'it could not provide comments until the proposals had legal standing and a board for naturopaths and herbal medicine practitioners is established under the Health Practitioner Regulation National Law Act 2009'*.[85]

Royal Australian College of General Practitioners (RACGP)

A search of the RACGP website finds a range of resources relevant to naturopaths and the practice of naturopathy, including the curriculum and syllabus for training of general practitioners in integrative medicine and articles in the Australian Family Physician Journal reporting the results of successive surveys of GPs. No specific policies were found.

Australian Integrative Medicine Association (AIMA)[86]

AIMA was the peak medical body representing the doctors and other health care professionals who practise integrative medicine.[87] AIMA was an independent not-for-profit organisation supported by its membership and governed by a volunteer board.

The AIMA website provided information on how medical practitioners work with naturopaths to integrate care. The website stated:

> *A working partnership between doctors and naturopaths is the obvious future for our professions and for the wellbeing of patients and practitioners... AIMA is actively working to facilitate true integration of care where doctors work collaboratively with naturopaths, other complementary and allied health professionals and the patient to manage their health and wellbeing.*

Nursing and allied health professional associations

No policies or position statements were located on the websites of nursing and allied health professional associations, such as the Royal Australian College of Nursing, the Australian Nursing and Midwifery Federation, Allied Health Professions Australia (AHPA), or the National Alliance of Self Regulating Health Professions (NASRHP).

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85 See AMA website.
86 On 29 October 2024 the AIMA Board announced a decision that AIMA will be wound up and its assets transferred to other organisations.
87 AIMA defines integrative medicine as a whole-person, patient-centred medical practice. It combines the best of conventional Western medicine with evidence-based complementary medicine and therapies. These practices are combined to provide the highest level of safe, effective healthcare for our patients. Integrative Medicine reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, health care professionals and disciplines to achieve optimal health and healing. It takes into account the physical, psychological and social wellbeing of the person with the aim of using the most appropriate, safe and evidence-based treatments available. See www.aima.net.au/about/

8.10 DISCUSSION

Several findings are evident from the analysis of mainstream institutions and how they recognise, engage with, or view naturopaths and herbalists.

First, most mainstream institutions that represent practitioners, hospitals and health services, and professional associations do not have formal positions or policies with respect to engaging with naturopaths and naturopathy. If there are stated positions, these mostly relate to complementary medicine in general rather than specifically to naturopaths.

Second, many organisations place strong emphasis on the need for evidence-based practice. In most of the materials found (submissions, position statements, information for consumers), a commonly expressed view is that complementary medicine practices and professions are either not evidence-based or the scientific evidence is deficient. This appears to present a significant barrier for organisations to accept, recognise, or engage with and embrace naturopaths and naturopathic practice.

Third, with respect to public and private insurance schemes, there is no specific reference to reimbursement for naturopathic services in any third-party compensation schemes, either public (Medicare, PBS, Veterans, Workers Compensation, Traffic Accident) or private, except for the workers compensation scheme in Victoria. It is apparent that with the removal of private health insurance rebates for complementary therapies including naturopathy, institutional recognition of the profession has taken a step backwards since the Lin Report was published.

By comparison, most insurance schemes provide rebates for services provided by the three registered complementary medicine professions (chiropractic, osteopathy and Chinese medicine) alongside other registered and unregistered allied health professions. These complementary medicine professions have also retained private health insurance rebates despite the changes arising from the Australian Government Review of Private Health Insurance Rebates; and osteopathy and chiropractic also have access to Medicare rebates (but not Chinese medicine). While many schemes use registration under the National Registration and Accreditation Scheme (NRAS) as the basis for granting provider rebate status, both public and private health insurance schemes provide rebates for several unregistered health professions such as speech pathology, audiology, and dietetics as well as a more recently established profession of exercise physiotherapy.

Fourth, while the policy intent of the decision to remove naturopathy and WHM programs from the Health Training Package was positive in that degree level is the appropriate educational standard for entry to the profession, there have been unintended consequences for these professions. In the absence of an effective mechanism of enforcement of this standard, the effect has been to deregulate education provision, with some private education providers now operating beyond the jurisdiction of any government quality assurance system as they continue to offer entry level programs marketed as advanced diplomas.

Finally, one area where progress has been made since 2005 is in naturopathy research and research capability. Apart from the NHMRC commissioned evaluations to support the 2020-21 Review of Australian Government Private Health Insurance Rebates, there is some evidence that naturopathy researchers have had some success under the competitive grants programs run by the NHMRC and the ARC. More significantly, since 2005 one research consortium (ARCCIM) and two new research institutes have been established, the latter with sizable financial contributions from private donors – the NICM Health Research Institute at Western Sydney University (with substantial funding from the Jacka Foundation) and more recently, the National Centre for Naturopathic Medicine at Southern Cross University (with funding from the Blackmore Foundation). Each of these research institutions has a stated aim to foster evidence-based practice.

8.11 CONCLUSIONS

Institutions matter. This chapter provides an overview of the status of naturopathy and WHM vis-a-vis other healthcare institutions, such as public and private health insurers, regulators, professional associations, and peak professional bodies.

The widespread but incorrect view that naturopathic and WHM practice are not 'scientific' or 'evidence based' appears to present a significant barrier for mainstream institutions to accept, recognise, or engage with naturopaths and herbalists as they deliver primary and preventive care to the Australian population.

While these professions appear to have made some progress in research capability, the professions have lost institutional status and benefits in the loss of private health insurance rebates and the loss of government accreditation of education programs for entry to practice as a naturopath or herbalist.

It appears the registered complementary medicine professions have been protected from these changes and that it is easier to achieve recognition and benefits when part of the NRAS. While some unregistered allied health professions have achieved institutional recognition and benefits without statutory registration under NRAS (for example, exercise physiologists), such professions do not face the attitudinal hurdles that naturopaths and herbalists face by virtue of their categorisation as 'T&CM' professions.

9
REGULATION OF THE NATUROPATHY AND WESTERN HERBAL MEDICINE PROFESSIONS

Anne-Louise Carlton

9.1 INTRODUCTION

Naturopaths are subject to a variety of laws that govern their practice and the products they prescribe or use. These laws span all levels of government – federal, state/territory and local government.

The Australian Constitution provides the Commonwealth with specific legislative powers, including the power to impose taxes, regulate corporations and trade, and powers with respect to quarantine and the provision of health and social welfare including pharmaceuticals (Lin et al., 2005: 255). Applying these powers, the Commonwealth Parliament has enacted laws that apply to naturopathy/WHM practice, including the regulation of therapeutic goods. State and territory laws address gaps and cover issues over which the Commonwealth has no constitutional powers, for example, in occupational regulation or statutory registration of health practitioners.

Laws that impact the practice of naturopaths and herbalists include: the criminal law; the civil law (the law of negligence and the law of contracts); laws that license businesses, equipment and occupations; laws that regulate specific activities such as employment, occupational health and safety; the use of medicines and therapeutic goods; laws that regulate the management of complaints, privacy and access to information; laws that authorise insurance rebates for health services; and public health laws that may impose practice obligations to deal with public health threats such as infectious diseases.

The purpose of this chapter is to provide an overview of the main laws that apply to and shape naturopathy/WHM practice in Australia, including the laws that regulate the use of herbs and nutritional medicines. The findings of the Lin Report (2005) with respect to regulation are summarised. The main types of occupational regulation are described and their key features compared. The extent to which these types of occupational regulation apply to the naturopathy/WHM professions in Australia is discussed. International developments in occupational regulation of naturopaths are summarised, with particular reference to those trends and developments relevant to regulation of the Australian naturopathic profession. Taking into account the risks of naturopathy/WHM practice identified in **Chapter 3** and the institutional context outlined in **Chapter 8**, some gaps in regulation are identified.

9.2 METHODOLOGY

The methodology for this study was modelled on that applied in the Lin Report (2005), with several modifications.

First, a search was undertaken for Acts and regulations relevant to the practice of naturopathy and WHM. This involved use of the **AustLII databases** to search for legislation in Australia. Key search terms used were the same as those used in the Lin Report, that is: complementary medicine; alternative medicine; naturopathy; Western herbal medicine; herbal medicine; herbs; therapeutic; health. However, unlike the Lin Report, the search term 'Chinese medicine' was not included since the focus was specifically on the professions of naturopathy and WHM rather than the broader traditional and complementary medicine (T&CM) professions.

Second, an internet search was undertaken for information and reports published since 2006 by health and consumer affairs authorities, on health practitioner regulation models and legislative and policy proposals relevant to the naturopathy profession. Search terms used included: naturopathy; naturopath; practitioner regulation; health workforce regulation; health practitioner regulation.

Table 9.1: List of agencies and regulators included in the website search

Jurisdiction	Agency/Regulator
CTH	Australian Government Department of Health Department of Health Therapeutic Goods Administration (TGA) Australian Government Productivity Commission Food Standards Australia New Zealand (FSANZ) Australian Competition and Consumer Commission (ACCC)
ACT	ACT Health ACT Human Rights Commission Access Canberra
NSW	NSW Health Health Care Complaints Commission Information and Privacy Commission NSW NSW Fair Trading
NT	NT Health Health and Community Services Complaints Commission Northern Territory Information Commissioner NT Consumer Affairs
QLD	Queensland Health Office of the Queensland Health Ombudsman Office of the Information Commissioner Office of Fair Trading (Department of Justice and Attorney-General)
SA	SA Health Health and Community Services Complaints Commissioner Privacy Committee of South Australia Consumer and Business Services South Australia
TAS	Tasmanian Government – Department of Health Health Complaints Commissioner Tasmania Consumer Affairs and Fair Trading Tasmania
VIC	Department of Health Health Complaints Commissioner Consumer Affairs Victoria
WA	Department of Health Health and Disability Complaints Office (Department of Health) Department of Mines, Industry Regulation and Safety (Consumer Protection)
Non-govt	Allied Health Professions Australia (AHPA) National Alliance of Self Regulating Health Professions (NASRHP)

Third, rather than undertaking a desk top analysis of the licensing laws of selected jurisdictions, the World Naturopathic Federation (WNF) 2021 report Naturopathy practice, effectiveness, economics & safety was accessed for relevant information about international developments in regulation of naturopaths.[88] This report, to which the authors of the current study contributed, provided an overview of the regulatory arrangements that apply to the naturopathy workforce across 197 countries.

9.3 THE LIN REPORT FINDINGS ON REGULATION OF NATUROPATHS AND NATUROPATHIC PRACTICE

The Lin Report provided a snapshot of the regulatory arrangements governing the practice of naturopathy and WHM in 2005. The report presented the state of play with respect to federal, state, and territory laws and regulations of relevance to naturopathic practice, including laws governing:

- manufacture and use of medicines and other therapeutic goods
- occupational licensing (statutory registration)
- business practices and consumer protection
- health complaints
- protection from public health risks, and
- privacy protection and access to health records and health information

The report also provided an overview of legislative controls in other countries with respect to complementary and alternative medicine (CAM) practitioners and products, specifically, laws in the European Union, the United Kingdom, New Zealand, Canada, and the United States of America.

At that time, while some Australian CAM professions were subject to statutory registration, (notably chiropractic, osteopathy and Chinese medicine), there was no registration scheme for the naturopathy/WHM professions and instead naturopaths and herbalists were 'self-regulated'. Under self-regulation arrangements, practitioners could choose to join a professional association that sets minimum qualifications for membership and standards for professional conduct and service delivery, but membership was not mandatory (Lin et al., 2005: 280). Lin & colleagues found that some countries were moving to regulate CAM professions, with evidence presented that some US states and Canadian provinces had introduced occupational licensing of the naturopathy profession.

Lin & colleagues raised several concerns about the regulatory arrangements for naturopathic practice in Australia – see **Textbox 9.1**.

Lin & colleagues concluded that the absence of statutory registration for naturopaths and WHM practitioners in Australia meant there were no consistent standards for protection of the public and recommendations were made to strengthen regulation (2005: 283).

88 See WNF 2021 report.

9.4 OVERVIEW OF KEY LAWS REGULATING NATUROPATHS & HERBALISTS PRACTICE AND PRODUCTS

Table 9.2 presents an overview of the laws relevant to naturopathy/WHM practice that were identified through the Austlii search of legislation.

Both the federal government and states and territories continue to regulate aspects of naturopathy/WHM practice under various generic regulatory regimes, in the following areas:

- occupational licensing (statutory registration)
- business practices and consumer protection
- eligibility for private health insurance rebates
- manufacture and use of medicines and other therapeutic goods
- management of health complaints
- protection from public health risks, and
- privacy protection and access to health records and health information

Since 2005, there have been legislative changes in some areas while others remain largely unchanged. While there are some consistencies across states and territories, there are also some important differences, particularly with respect to the 'code of conduct' and 'prohibition order' powers in relation to non-registered health care workers (which includes naturopaths and herbalists). These are discussed in the sections below.

Textbox 9.1: Findings from the Lin Report (2005) concerning the regulation of naturopaths and WHM practitioners

Deficiencies in self-regulation – inconsistency of educational and professional standards, disciplinary procedures that lack transparency, and a plethora of laws that impinge on practice and on the herbs and nutritional supplements that are the tools of trade of naturopaths and WHM practitioners.

Fragmented industry representation reinforced by government policy decisions – the Australian Taxation Office (ATO) recognises multiple professional associations whose standards are often inconsistent and are free of any independent scrutiny, creating a system that *lacks consistency and transparency*, is difficult to understand, and provides only *minimal public protection*.[89]

Naturopaths denied access to their tools of trade – the scheduling system for naturopathic medicines under state and territory drugs and poisons laws denies access for competent naturopaths to their 'tools of trade' and there is *no effective system for regulation of the quality and safety of raw herbs* intended for extemporaneous dispensing.

Limitations in consumer protection law – consumer protection laws and the common law provide some protections to the public where information about products or services is false and misleading, goods sold are not fit for the purposes intended, or the practitioner has been negligent; however, *litigation is stressful and expensive* and its outcomes can be *unpredictable*.

Limitations in avenues for consumer complaint – complaints about the professional conduct of practitioners may be lodged with state and territory health.

Source: Lin et al., 2005: 280-83

89 Under the federal goods and services tax (GST) legislation, only practitioners who are members of a 'recognised professional association' are able to charge GST-free fees for patient consultations.

Table 9.2: Key federal, state and territory laws governing naturopathic products and practice in Australian jurisdictions

Jurisdiction	CTH	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Laws governing business practice and protection of consumers	A New Tax System (Goods and Services) Act 1999	---	---	---	---	---	---	---	---
	Biosecurity Act 2015	---	---	---	---	---	---	---	---
	Competition and Consumer Law 2010	Fair Trading (Australian Consumer Law) Act 1992	Fair Trading Act 1987	Consumer Affairs and Fair Trading Act 1990	Fair Trading Act 1989	Fair Trading Act 1987	Australian Consumer Law (Tasmania) Act 2010	Australian Consumer Law and Fair Trading Act 2012	Fair Trading Act 2010
Health complaints laws	---	Human Rights Commission Act 1995	Health Care Complaints Act 1993	Health and Community Services Complaints Act	Health Ombudsman Act 2013	Health and Community Services Complaints Act 2004	Health Complaints Act 1995	Health Complaints Act 2016	Health and Disability Services (Complaints) Act 1995
Health care worker Code of conduct and prohibition order powers	---	Human Rights Commission Regulation 2023	Public Health Regulation (Reg 99 and Schedule 3) Health Care Complaints Act 1993 (Division 6A)	---	Health Ombudsman Act 2013 (Part 7 Division 2) Health Ombudsman Regulation (Section 5) The National Code of Conduct for Health Care Workers (Queensland)	Health and Community Services Complaints Act 2004 (Part 6 Division 5) Health and Community Services Complaints Regulations 2019	Health Complaints Amendment (Code of Conduct) Act 2018 (not yet commenced)	Health Complaints Act 2016 (Part 8 & Schedule 2)	Health and disability services complaints (Amendment) Act 2021 (commenced 2023)
Statutory registration (occupational licensing)		Health Practitioner Regulation National Law (ACT) Act 2010	Health Practitioner Regulation National Law (NSW) No. 86a of 2009	Health Practitioner Regulation National Law (National Uniform Legislation) Act 2010	Health Practitioner Regulation National Law (Queensland) Health Ombudsman Act 2013	Health Practitioner Regulation National Law (South Australia) Act 2010	Health Practitioner Regulation National Law (Tasmania) Act	Health Practitioner Regulation National Law (Victoria) Act 2009	Health Practitioner Regulation National Law (WA) Act 2010
Public health protection laws and pandemic management laws		Public Health Act 1997	Public Health Act 1991	Public and Environmental Health Act 2011	Public Health Act 2005	Public Health Act 2011	Public Health Act 1997	Public Health and Wellbeing Act 2008	Public Health Act 2016
		COVID-19 Emergency Response Act 2020	COVID-19 Legislation Amendment (Emergency Measures) Act 2020	Chief Health Officer Directions	COVID-19 Emergency Response Act 2020 Disaster Management Act 2003	COVID-19 Emergency Response Act 2020	COVID-19 Disease Emergency (Miscellaneous Provisions) Act 2020	COVID-19 Omnibus (Emergency Measures) Act 2020	Public Health Amendment (COVID-19) Response Act 2020
Health information and privacy laws	Privacy Act 1988	Health Records (Privacy and Access) Act 1987	Health Records and Information Privacy Act 2002	Information Act 2002	Information Privacy Act 2009	Freedom of Information Act 1991 (public health services) (private health services)	***Right to Information Act 2009*** (information held by public authorities)	Health Records Act 2003	Freedom of Information Act 1992 (public health services) Privacy Act 1988 (Cth) (private health services)
Laws governing medicines & other therapeutic goods	Therapeutic Goods Act 1989	Medicines, Poisons and Therapeutic Goods Act 2008	Poisons and Therapeutic Goods Act 1966	Medicines, Poisons and Therapeutic Goods Act 2012	Privacy Act 1988 (Cth)	Controlled Substances Act 1984	Therapeutic Goods Act 2001 Poisons Act 1971	Therapeutic Goods (Victoria) Act 2010 Drugs, Poisons and Controlled Substances Act 1981	Medicines and Poisons Act 2014

9.5 OCCUPATIONAL REGULATION AND REGULATION OF HEALTH COMPLAINTS

Types of occupational regulation

Review of government websites and policy documents suggests a consensus as to the types or models of regulation that apply to the health professions in Australia.

Textbox 9.2 describes four main types of occupational regulation as:

- Voluntary certification (also known as self-regulation)
- Co-regulation
- Negative licensing (also known as code regulation)
- Statutory registration (also known as occupational licensing)

Textbox 9.2: Typology for defining types of occupational regulation that apply to the health workforce

Voluntary certification

Under voluntary certification, there is no underpinning statute enacted by government that confers powers on a regulator to license members of the profession or occupation. Rather, practitioners join together to establish an association with a constitution, bylaws, and rules for its members. The association may be registered as a body corporate under the relevant law of a country.

On joining the association, a practitioner member agrees to abide by the rules of the association and its code of ethics, and their name and other details will generally appear on a web-based register maintained by the association. The association may also operate a consumer complaints mechanism, and the rules may provide for members to be expelled for serious breaches of the code of ethics. However, the system is entirely voluntary – practitioners can choose not to join the association and still practise, and they can continue to practise if expelled from an association for reasons of misconduct.

A variation on this model is where the entity that maintains the practitioner register may be initiated by the professional association but established as a separate legal entity, with a specific mandate to carry out regulatory functions on behalf of the profession. While there is organisational separation of the regulatory functions from the membership representation and advocacy functions, the arrangements continue to be entirely voluntary. Consumers, insurers, and health service providers may rely on information provided by the register of practitioner members for trusted advice about who is qualified to practise the profession, but there is no direct involvement or recognition from government.

Co-regulation

Co-regulation is similar to voluntary certification. The key difference is that some of the functions of the self-regulating professional association may be either delegated from or recognised by government. This government recognition or delegation may be conditional on the certification body meeting specified standards in relation to governance and its certification standards and processes. This recognition process establishes, in effect, a partnership between government and the certifying body, and the benefits that flow to practitioners from certification create incentives for practitioners to comply with the professional association's standards.

Negative licensing

Under a negative licensing system, there is no legal barrier to entry to an unregistered profession – anyone can set out their shingle and practise, no matter what their level of training or skill. However, a law is enacted that provides a mechanism for a statutory regulator to receive and investigate complaints about a practitioner. The regulator may issue a prohibition or 'banning order' to remove a practitioner from practice when the regulator finds that a practitioner has committed an offence or a breach of minimum standards of practice and their continued practice presents a serious risk to the public. There may be offences for breach of a prohibition order and an online searchable public register of prohibition orders.

Occupational licensing or statutory registration

Under an occupational licensing system, the purpose and functions of the system are not determined by the profession alone (as in the case of voluntary certification) but are generally set out in legislation or other instruments of authority and are subject to public scrutiny (through the responsible parliament and minister). The legislation establishes a regulatory body with powers to register/license and regulate practitioners. Entry to a regulated profession is limited to those the regulatory body considers to be properly qualified and of good character. This gate-keeping role is underpinned by statute, with powers for the regulatory body to prosecute unregistered persons who 'hold themselves out' as qualified to practice the profession when they are not. The statute provides an effective mechanism for restricting entry to the profession, and disciplinary powers to deal with practitioners whose practice falls below an acceptable standard.

There are two distinct models of occupational licensing: reservation of title and reservation of practice. While registration/licensing laws generally prohibit unrgistered/unlicensed persons from using restricted professional titles or pretending to be qualified and registered when they are not (reservation of title), some laws go further, prohibiting unregistered persons from providing certain types of clinical services (reservation of practice). Such laws create an exclusive scope of practice, in effect a monopoly, for the profession or occupation concerned.

Source: Adapted from WHO WPR (2016); Carlton (2017); AHMAC (2018); Carlton et al. (2024)

Table 9.3 lists some key features or parameters of occupational regulation against which these four types are compared.

Table 9.3 Occupational regulation types – key parameters

Parameter	Type of occupational regulation			
	Voluntary Certification	Co-regulation	Negative licensing	Occupational licensing/ statutory registration
Statutory basis	NO	MAYBE	YES	YES
Enforceable minimum qualifications for entry to practice	NO	NO	NO	YES
Probity checking of persons prior to entry to practice	NO	NO	NO	YES
Accreditation of qualifying programs for entry to practice	YES	MAYBE	NO	YES
Enforceable minimum standards of practice	NO	NO	YES	YES
Mandatory continuing professional development (CPD)	YES members	MAYBE	NO	YES
Legal obligation to report professional misconduct by fellow practitioners	NO	NO	YES	YES
Powers to monitor practitioner compliance with practice standards	NO	NO	NO	YES
Powers to impose conditions or limitations on a practitioner's practice	NO	NO	YES	YES
Power to issue practice guidelines/codes	YES	NO	NO	YES
Mechanism for authorising use of restricted (scheduled) medicines	NO	NO	NO	YES
Complaints and disciplinary powers	YES members only	MAYBE	YES	YES
Powers to remove unfit practitioners from practice	NO	NO	YES	YES
Offences and penalties for unauthorised use of professional titles	NO	NO	NO	YES
A publicly accessible register of qualified practitioners	MAYBE	MAYBE	NO	YES
A publicly accessible register of disqualified or barred practitioners	NO	NO	YES	YES
Publication of disciplinary decisions	NO	NO	YES	YES
Protection from civil liability for board members and/or staff discharging regulatory functions	NO	NO	YES	YES

Source: *Carlton et al. (2024)*

Changes in the laws regulating health occupations and health complaints

Since 2005, the legal framework governing the regulation of health professions and occupations and the management of health complaints has been subject to substantial reform, including reconfiguration of regulatory institutions. Two developments are of particular significance.

First, the establishment of the NRAS for the health professions, enacted through a series of state and territory laws known together as the *Health Practitioner Regulation National Law.*

Second, the passage of legislative amendments to health complaints laws in some states and territories to strengthen the powers of their respective health complaints commissioners to deal with non-registered practitioners (health care workers) who are incompetent, unfit to practise, or who engage in conduct that presents an ongoing risk to public health and safety.

Establishment of the National Registration and Accreditation Scheme (NRAS)

A report published in 2006 by the Australian Government Productivity Commission titled *Australia's health workforce* highlighted significant barriers to workforce

mobility, supply, efficiency, and safety caused by the fragmented regulatory arrangements across Australia and across professions. In July 2006, the Council of Australian Governments (COAG) agreed in principle to simplify and improve the consistency of current arrangements by establishing a single national registration scheme for health professionals and a single national accreditation scheme for health education and training.

In March 2008, the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions* was signed by the Prime Minister, the premiers of all states and the chief ministers of the territories. This intergovernmental agreement set out the framework under which the National Registration and Accreditation Scheme (NRAS or the National Scheme) would operate.

The NRAS commenced in July 2010. It is designed to ensure that all regulated health practitioners are registered against consistent, high-quality national professional standards and can practise across state and territory borders without having to re-register in each jurisdiction.[90]

These institutional reforms have reconfigured the Australian regulatory institutions with respect to the registration and regulation of health practitioners. Practitioners who qualify in one of 16 regulated health professions may now register once and practise anywhere in Australia. Practitioners are regulated by one of 15 National Boards, supported by a single national agency – Ahpra.

In 2018, the Australian Health Ministers' Advisory Council (AHMAC) published a guidance document on the criteria and process for adding new professions to the NRAS (AHMAC 2018).

This document sets out the process through which a professional association (or other entity) may make a submission for inclusion of their profession in the NRAS and how such submissions are assessed. While the initial submission must address the same 'AHMAC criteria' that have been in place since 1995, the next step involves a regulatory impact assessment (RIA) to assess the costs and benefits of a range of feasible options including the option of no change. Federal, state and territory Health Ministers must be convinced there is a prima facie case of the need for statutory registration before they will allocate the resources required for an RIA.

Since the NRAS was enacted, only one profession (paramedicine) has been subject to a Ministerial Council agreed RIA process and in 2016, the National Law was amended to include this profession within the scheme. A second profession (social work), unable to secure the unanimous agreement of all Health Ministers, has been refused inclusion in the NRAS. Instead, the South Australian Government has legislated to establish a registration scheme for the social work profession.[91] This development suggests that while a nationally agreed regulatory assessment process is in place (described above), the option remains for an individual state or territory to 'go it alone', that is, to enact local legislation to register and regulate a profession in circumstances where jurisdictions have been unable to reach national agreement to extend the scope of the NRAS.

Introduction of the National Code of Conduct for health care workers

In 2015, all states and territories agreed to separately legislate to strengthen the powers of their respective health complaints commissioners, in accordance with a nationally agreed policy framework (AHMAC 2015).[92] To date, the agreed negative licensing or 'code regulation' scheme has been legislated and is operating in five states (NSW, SA, Qld, Vic and WA) and one territory (ACT) and legislated but not yet commenced in Tasmania.[93] The Northern Territory is yet to legislate to implement the national agreement and no recent information was found to indicate legislation is in progress.[94]

Table 9.4 provides details of the Codes of Conduct and prohibition order powers that apply in each state and territory that has enacted the scheme.

The six schemes are enacted and operate along broadly similar lines – see Textbox 9.3.

90 See Ten years of national health practitioner regulation in Australia p. 7.
91 See the Social Workers Registration Act 2021 (SA).
92 Victorian Department of Health on behalf of the Australian Health Ministers' Advisory Council, Final Report A National Code of Conduct for health care workers. 2015.
93 See the Health Complaints Amendment (Code of Conduct) Act 2018 (Tas). The changes were enacted in 2018 but have not yet commenced – see https://www.healthcomplaints.tas.gov.au/national-code-of-conduct
94 In 2017, the NT Department of Health published an Information Paper on proposed changes to give effect to the National Code of Conduct and prohibition order powers, but there is no indication of any progress in framing the necessary legislative changes.

Textbox 9.3: Key features of code regulation (negative licensing) schemes

- A health complaints law is enacted (or amended) that a law is enacted (or an existing law is amended) to enable a statutory code of conduct to be made by regulation and confer powers on a regulator (a state-based health complaints commissioner supported by an administrative office) to take regulatory action for breaches of the code.
- The law contains definitions of 'health service' and 'health care worker' (or equivalent term such as 'non-registered health practitioner'). These definitions determine the scope of the negative licensing powers and to whom these powers apply.
- The statutory code of conduct made by regulation sets minimum standards of practice for all non-registered health care workers who provide a health service, regardless of their discipline or occupation, the nature of their practice, the titles they use, or how they badge, describe, or advertise the services they provide. See for example, the regime in Queensland, Australia.[95]
- The regulator has statutory powers to receive and investigate complaints from health service users or other interested parties and has the power, if warranted, to issue a 'prohibition order', to attach conditions to a worker that limit their scope of practice, or to ban them from practice altogether.
- If a health care worker who is subject to a prohibition order breaches the order, they may be prosecuted through the courts. Offenses are punishable by fines or up to two years imprisonment.
- Each regulator keeps an online searchable register of prohibition orders which provides information to the public about the identity of prohibited or banned workers and details of the misconduct and the order issued.[96] The websites may include other information such as warning statements, press releases, and links to orders published in other states, to prevent those subject to a prohibition order from skipping across the border to continue practising.

Under these schemes, there is no legal barrier to prevent a person from entering a non-registered health profession – anyone can set out their shingle and practise, no matter what their level of training or skill. However, these laws provide powers to prevent such persons from continuing to provide health services if they have committed an offence or a breach of minimum standards of practice and their continued practice presents a serious risk to the public. In 2020 amendments to the powers of the NSW Health Care Complaints Commission,[97] the prohibition order powers of the Commission were extended to enable regulatory action against health organisations as well as individual practitioners and in September 2022, the *Public Health Regulation 2022* was amended to introduce a *Code of Conduct for health organisations.*[98]

95 Queensland Health. The National Code of Conduct for Health Care Workers (Queensland). 2015.
96 See for example NSW Health Care Complaints Commission. Prohibition Orders. 2021.
97 See Health Legislation (Miscellaneous Amendments) Act 2020 (NSW)
98 See Code of Conduct for health organisations.

TABLE 9.4: State and territory negative licensing (code regulation) laws and regulators

Jurisdiction	Act	Relevant provisions	Regulator and Code of Conduct – website links	Comments
ACT	Human Rights Commission Act 2005	Human Rights Commission Regulation 2023	ACT Human Rights Commission www.hrc.act.gov.au/health/code-of-conduct-for-health-care-workers	Commenced 2023
NSW	Health Care Complaints Act 1993	Division 6A Action against non-registered health practitioners	Health Care Complaints Commission	Amendments in 2022 to extend scope of HCCC prohibition order powers to cover health organisations. See Public Health Act 2010, Division 7A Action against relevant health organisations and Public Health Regulations 2022 Schedule 4.
	Public Health Act 2010	Part 7, Division 2 and Division 3		
	Public Health Regulation 2022	Sections 116-118. Schedule 3		
NT	No legislation enacted to give effect to prohibition order powers			
QLD	Health Ombudsman Act 2013	Part 7, Division 2 Interim prohibition orders. Part 8A Prohibition orders	Office of the Health Ombudsman	
	Health Ombudsman Regulation 2014	Section 5 & National Code of Conduct for health care workers (Queensland)		
SA	Health and Community Services Complaints Act 2004	Part 6 Division 5	Health and Community Services Complaints Commissioner	
	Health and Community Services Complaints Regulations 2019	Regulation 7	Code of Conduct	
TAS	Health Complaints Act 1995 as amended by Health Complaints Amendment (Code of Conduct) Act 2018	Part 6 Division 5	Health Complaints Commissioner Tasmania	Provisions enacted but not yet commenced.
VIC	Health Complaints Act 2016	Part 8 Schedule 2 General code of conduct in respect of general health services	Health Complaints Commissioner General health service provider General Code of Conduct	Terms used are 'General health service provider', 'general health services' and 'General Code of Conduct'.
WA	Health and Disability Services (Complaints) Act 1995 as amended by the Health and Disability Services (Complaints) Amendment Act 2022	Part 3	Government of Western Australia Health and Disability Services Complaints Office	Provisions enacted October 2022 but not yet commenced.

9.6 LAWS REGULATING BUSINESS PRACTICE AND CONSUMER PROTECTION

Goods and Services Tax (GST) law

Under the federal GST legislation, A New Tax System (Goods and Services Tax) Act 1999 (Cth) (the GST Act), a person may obtain GST-free status for the provision of naturopathy and herbal medicine services.

Under section 38.10(1) of the GST Act, the supply of a health service is GST-free if:

- *the service is of a kind specified in the Table in that section*
- *the supplier is a 'recognised professional' in relation to the supply of that service, and*
- *the supply would be generally accepted, in the profession associated with supplying services of that kind, as being necessary for the appropriate treatment of the recipient of the service.*

Textbox 9.4: Goods and Services Tax (GST) law

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- the supplier is a 'recognised professional' in relation to the supply of that service, and
- the supply would be generally accepted, in the profession associated with supplying services of that kind, as being necessary for the appropriate treatment of the recipient of the service.

Naturopathy and herbal medicine are specified as health services in the table in section 38.10(1). Under section 38.10(4), the supply of goods (such as herbal medicines) is also GST-free if it is made to a person by the naturopath in the course of supplying the GST-free service and it is supplied, used, or consumed at the premises at which the service is supplied.

Because no Australian state or territory currently requires naturopaths to be registered (or approved or have permission) to provide their professional services, a naturopath who wishes to be classed as a 'recognised professional' for the purpose of providing GST-free services must be a member of a professional association that has 'uniform national registration requirements' for naturopaths.

The website of the Australian Taxation Office (ATO) states that a professional association that has uniform national registration requirements is not defined in the GST Act and that if a particular association wants confirmation of its status, a specific ruling may be sought from the ATO. It is understood that several national associations with naturopath members have applied for a specific ruling.[99]

Naturopathy and herbal medicine are specified as health services in the table in section 38.10(1) referred to above. Under section 38.10(4), the supply of goods (such as herbal medicines) is also GST-free if that supply is made to a person by the naturopath, in the course of supplying the GST-free service, and it is supplied, used or consumed at the premises at which the service is supplied.

Because no Australian state or territory currently requires members of the naturopathy profession to be registered (or approved or have permission) to provide their professional services, a naturopath who wishes to be classed as a 'recognised professional' for the purpose of providing GST-free services must be a member of a professional association that has 'uniform national registration requirements' for naturopaths.

The website of the Australian Taxation Office (ATO) states that a professional association that has uniform national registration requirements is not defined in the GST Act and that if a particular association wants confirmation of its status, a specific ruling may be sought from the ATO. It is unclear how many national professional associations with naturopath members have taken this step.

Lin & colleagues were critical that the ATO has recognised, for GST purposes, multiple sets of standards for multiple professional associations. Recognition of the standards of multiple professional associations means that a practitioner found to have breached the standards of one association can join another association that has national standards and maintain their GST-free status as a 'recognised professional' (2005: 257).

In twenty years, this situation has not changed. In 2023, at least four professional associations – ANTA, ATMS, CMA, and NHAA – indicated on their websites that their members are eligible to provide GST-free services. Each sets its own membership and practice standards independently of the others.

Competition and Consumer Act 2010 (Cth)

Since the Lin Report was published, there have been some changes in the laws that regulate trade practices, business licensing, and consumer protection. The Australian Parliament has enacted new legislation to replace the Trade Practices Act 1974.

The Competition and Consumer Act 2010 (the CCA) regulates fair trading in Australia and governs how all businesses in Australia (including naturopathy businesses) must deal with their customers, competitors, and suppliers. While the Act is a national law, each state and territory has enacted additional consumer protections within their own fair trading laws. See **Table 9.2** for the list of state and territory fair trading laws.

The Australian Competition and Consumer Commission (ACCC) administers and enforces the CCA along with state and territory regulators. The ACCC states that:

- the Act promotes fair trading between competitors while also ensuring that consumers are treated fairly
- the law is designed to enable all businesses to compete on their merits in a fair and open market, while also ensuring businesses treat consumers fairly
- consumer protection provisions are in the Australian Consumer Law (ACL), which is contained in a schedule to the CCA. The ACL governs business

99 Four professional associations – ANTA, ATMS, CMA, and NHAA – indicate on their websites that members are eligible to provide GST-free services.

behaviour when advertising and interacting with consumers. It also sets out a number of consumer rights, including specific guarantee rights

- state, territory, and federal regulators including the Australian Competition and Consumer Commission (ACCC) enforce the ACL
- only the ACCC enforces the competition law, which is set out in the CCA. If a business fails to comply with its obligations under the ACL or CCA, it is breaking the law (ACCC: 2).

The ACCC regulates advertising and promotions. A business must be able to prove any claim they make or advertise:

- claims should be true, accurate and based on reasonable grounds
- online product and service reviews should be independent and genuine
- special rules apply to cash back promotions, prizes, gift cards and discount vouchers

The ACCC has powers to issue infringement, substantiation and public warning notices and maintains a Public warning notice register. However, no public warnings were found relating to naturopaths or naturopathic practices.

9.7 LAWS REGULATING MEDICINES AND OTHER THERAPEUTIC GOODS

Since 2005, the legal framework governing the regulation of medicines and therapeutic goods has been subject to minor amendments and five out of eight states and territories have enacted new legislation governing regulation of medicines and therapeutic goods (ACT, NT, QLD, VIC and WA). While the general structure and operation of the federal regulatory regime and the division of responsibilities with state and territories remains largely unchanged, there have been changes to the naming and operation of statutory committees as well as some updating of regulations and guidelines. The current arrangements are described below.

Therapeutic Goods Act 1989 (Cth)

The Therapeutic Goods Act 1989 continues to apply, setting out the legal requirements for the import, export, manufacture, and supply of therapeutic goods in Australia. It details the requirements for registration, listing or including medicines, medical devices, or biological products on the *Australian Register of Therapeutic Goods* (ARTG). The Act, along with Regulations and Determinations and Orders made under it are updated from time to time. Scheduling of substances in the Poisons Standard and the safe storage of therapeutic goods are covered by state and territory laws (see Table 9.2).

In Australia, medicinal products containing such ingredients as certain herbs, vitamins and minerals, nutritional supplements, homoeopathic medicines, and aromatherapy products are referred to as 'complementary medicines' and are regulated as medicines by the TGA under the *Therapeutic Goods Act 1989* (the TG Act) and the supporting *Therapeutic Goods Regulations 1990* (the TG Regulations) (ARGCM 2018: 12).

The Australian Government Department of Health TGA publication *Australian regulatory guidelines for complementary medicine V7.2 February 2018* (ARGCM) provides an overview of the following key elements of the regulatory framework.

Australian Register of Therapeutic Goods

The TG Act is administered by the TGA and provides a uniform framework for import, export, manufacture, and supply of therapeutic goods unless they are exempt from the requirements. Any therapeutic good for which indications are made must be entered on the Australian Register of Therapeutic Goods (ARTG) before it can be legally imported, exported, manufactured, or supplied for use in Australia (ARGCM 2018: 12).

Complementary medicines are either registered or listed on the ARTG based on their ingredients and the indications made for the medicine, with most complementary medicines listed rather than registered (ARGCM 2018: 13).

Some medicines are exempt from the requirement to be listed or registered on the ARTG (see Schedule 7 of the TG Act). Exempt medicines include: medicines that are dispensed or extemporaneously compounded by a practitioner for a particular person, certain homoeopathic medicines, and starting materials used in the manufacture of therapeutic goods (except when pre-packaged for supply for other therapeutic purposes or formulated as a dosage form) (ARGCM 2018: 15).

Advisory Committee on Complementary Medicines (ACCM)

ACCM is a statutory advisory committee that provides expert advice at the request of the Minister or Secretary for Health, on the safety, efficacy, and manufacturing quality of a complementary medicine in the Australian Register of Therapeutic Goods. ACCM was formed in January 2010 under Regulation 39 of the *Therapeutic Goods Regulations 1990* and the members are appointed by the Minister for Health.

ACCM superseded the Complementary Medicines Evaluation Committee (CMEC) and has an increased focus on the advisory role within the regulatory framework of complementary medicines. Membership comprises of professionals with specific scientific, medical or clinical expertise as well as those with experience in consumer health issues relating to complementary medicines.

Advisory Committee on Medicines Scheduling (ACMS)

The ACMS was established to advise and make recommendations to the Secretary of the Department of Health (or delegate) on the level of access required for medicines and in some instances, chemicals. Under revised scheduling arrangements, which took effect on 1 July 2010, the Secretary to the Department of Health (Health) (or the Secretary's delegate) superseded the National Drugs and Poisons Schedule Committee (NDPSC) as the decision maker for the scheduling of medicines and chemicals.

Scheduling is a classification system that controls how medicines and chemicals are made accessible to consumers based on the substances contained within them. Substances are grouped into Schedules according to the appropriate level of regulatory control over their availability (e.g. Schedule 4 – medicines available only by prescription; Schedule 2 – medicines available over the counter in pharmacies).

Advertising of therapeutic goods

Section 42AA of the Act provides for sponsors to provide directly and exclusively to health professionals advertising material that is exempt from complying with the advertising requirements in the Act and the Regulations. Section 42AA of the Act also exempts those health professionals from the advertising rules when they give advice to their patients (ARGCM 2018: 17).

This exemption is relied on by herbal medicine suppliers when marketing practitioner-only medicines to customers – some health professional associations provide their naturopath/WHM members with 'Therapeutic Goods Advertising exemption certificates', advising the member they may receive advertising material from sponsors that are exempt from complying with usual advertising requirements.

While such certificates are not issued by the TGA (ARGCM 2018: 17), these arrangements provide an incentive for naturopaths to join an association that is on the TGA's list of associations whose members receive this type of advertising material.

Advertisements for therapeutic goods directed exclusively to healthcare professionals are governed by industry codes of practice and are not subject to the Therapeutic Goods Advertising Code.

Key documents posted on the TGA website are set out in Textbox 9.5.

Textbox 9.5: Federal Government Therapeutic Goods Administration standards for regulation of complementary medicines

Therapeutic Goods (Complementary Medicines – Information That Must Accompany Application for Registration) Determination 2018 – this sets out the kind of information which must accompany an application for the registration of a complementary medicine, and the form in which the application must be submitted

Therapeutic Goods (Complementary Medicines – Information That Must Accompany Application for Section 26AE Listing) Determination 2018 – this sets out the kind of information which must accompany an application for the listing of a complementary medicine under section 26AE of the Therapeutic Goods Act 1989 and the form in which the application must be submitted

Therapeutic Goods (Permissible Indications) Determination (No. 1) 2021 – this specifies the indications that are permitted for use in a medicine listed in the Australian Register of Therapeutic Goods under sections 26A or 26AE of the Therapeutic Goods Act 1989 and any requirements associated with their use in such medicines, and

Therapeutic Goods (Permissible Ingredients) Determination (No. 3) 2022 – this specifies those ingredients that may be contained in a medicine that is listed in the Australian Register of Therapeutic Goods under section 26A or 26AE of the Therapeutic Goods Act 1989, and requirements in relation to the inclusion of those ingredients in such medicines.

Regulation of medicines

In 2005, authorisation for health practitioners to use (obtain, possess, use, sell, or supply) medicines listed in the nationally agreed *Standard for Uniform Scheduling of Drugs and Poisons* (the SUSDP) was conferred under state and territory drugs and poisons laws. The inclusion of substances in the SUSDP results in some restriction of prescribing, for instance substances in Schedules 2-4 of the SUSDP may be prescribed only by specified registered health practitioners.

When the *Health Practitioner Regulation National Law* took effect in 2010, consequential changes were made to state and territory drugs and poisons laws. While each state and territory medicines law includes multiple mechanisms for authorising the possession, administration, prescribing, and supply of scheduled medicines (such as director-general or Chief health officer orders, standing orders etc), the main mechanism for registered health practitioners to be authorised to prescribe is via an 'endorsement' of a practitioner's registration granted by the responsible National Board (except for medical practitioners and dentists who do not require an endorsement to enable prescribing). The Ministerial Council approves the general scope of a scheduled medicines endorsement granted by a National Board and which National Boards have this endorsement power. So far, only the National Boards for optometrists, podiatrists, nurses and midwives, and paramedics have powers to grant a scheduled medicines endorsement to their registrants.

Despite these changes, the situation has not altered much for naturopaths (although the SUSDP has been renamed the Standard for Uniform Scheduling of Medicines and Poisons or 'the Poisons Schedule').[100] Since naturopaths are not registered under the NRAS, they are not authorised to prescribe scheduled medicines, even those in herbal form that naturopaths are trained to prescribe.

Biosecurity Act 2015 (Cth)

Since 2005, the Australian Parliament has enacted new legislation to replace the Quarantine Act 1908. The *Biosecurity Act 2015* provides for the prevention, elimination, minimisation and management of biosecurity risks. The Act applies to Australia, and its external territories including Norfolk Island, Christmas Island, and the Cocos (Keeling) Islands. It establishes a regulatory framework for the management of the risks of pests and diseases entering Australian territory and causing harm to animal, plant and human health, the environment, and the economy.

Goods and conveyances travelling to Australia are subject to biosecurity control as soon as they enter Australian airspace or the coastal sea of these areas which generally extends 12 nautical miles from the coast. Section 19 defines 'goods' to include plants, animals, pests, and any other article, substance, or thing. The Act provides powers for the Governor-General to declare a biosecurity emergency when a disease or pest poses a severe and immediate threat of harm and the Minister for Health may determine emergency requirements to prevent or control the spread of a human disease during a human biosecurity emergency.[101] This means that herbs used in naturopathic practice that are imported into Australia are subject to the requirements of the *Biosecurity Act*.

9.8 LAWS THAT PROTECT AND REGULATE PUBLIC HEALTH

Since 2005, there have been some changes to public health laws that have impacted the practice of naturopathy, particularly with respect to infection prevention and control.

For instance, every state and territory has legislated to empower the Minister for Health or Premier to declare a public health emergency and for a statutory officer (such as the Minister, Director of Public Health, Chief Health Officer or Chief Public Health Officer) to issue enforceable orders requiring actions of the entire population or specific groups such as health care workers. Such actions may include isolating or staying at home, mask wearing, vaccinations for health workers, and lockdown of health services. These powers have been exercised in every state and territory during the COVID-19 pandemic, with mandatory mask wearing and closure of naturopathy clinics at the height of the pandemic.

Table 9.5 sets out the relevant provisions in state and territory public health laws.

100 See an electronic version of the Poisons Schedule.
101 See sections 477 and 478 of the Biosecurity Act 2015 (Cth).

Table 9.5: State and territory public health laws that impact naturopathy practice

Jurisdiction	Act	Relevant provisions	Website
ACT	Public Health Act 1997	Part 6C Section 120 Emergency actions and directions	https://www.covid19.act.gov.au/restrictions/act-public-health-directions https://www.covid19.act.gov.au/management/public-health-declaration
NSW	Public Health Act 2010	Section 7 Power to deal with public health risks generally	https://www.health.nsw.gov.au/Infectious/covid-19/Pages/public-health-orders.aspx
NT	Public and Environmental Health Act 2011	Section 57B and 57C	https://coronavirus.nt.gov.au/chief-health-officer-directions
QLD	Public Health Act 2005	Chapter 8 Public Health Emergencies Sections 323 and 362B	https://www.health.qld.gov.au/system-governance/legislation/cho-public-health-directions-under-expanded-public-health-act-powers
SA	Public Health Act 2011	Part 11 Management of significant emergencies Section 90C	https://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/conditions/infectious+diseases/covid-19/response/covid-19+requirements+under+the+public+health+act
TAS	Public Health Act 1997	Division 2 Section 184	https://www.coronavirus.tas.gov.au/ https://www.health.tas.gov.au/sites/default/files/2021-12/Guidelines_for_Notifying_Coronavirus_Disease_2019_COVID-19_DoHTasmania2021.pdf
VIC	Public Health and Wellbeing Act 2008	Part 8A	https://www.health.vic.gov.au/covid-19/pandemic-order-register https://www.health.vic.gov.au/covid-19/victorias-pandemic-management-framework
WA	Public Health Act 2016	Parts 12 and 12A Section 167	https://www.wa.gov.au/government/document-collections/covid-19-coronavirus-state-of-emergency-declarations

9.9 LAWS THAT PROTECT PRIVACY AND REGULATE ACCESS TO PATIENT HEALTH INFORMATION

Since 2005, there have been few changes to the legal framework governing the regulation of privacy and access to personal health information.

The Privacy Act 1988 (Cth) is the principal piece of Australian legislation protecting the handling of personal information about individuals. It applies to: Australian Government agencies; organisations with an annual turnover of $3 million or more (sole traders, body corporates, partnerships, and unincorporated associations); and private sector health service providers (including naturopaths) with a turnover of less than $3 million.

The Act sets minimum privacy standards that must be met by all private sector health service providers concerning the collection, use, storage, and disclosure of personal information. Australian privacy law gives individuals a general right to request access to the health information a health service provider holds about them.

In addition, some states and territories have enacted specific legislation governing health records – see **Table 9.6**. For instance, Victoria's *Health Records Act 2001* establishes a framework to protect the privacy of individuals' health information. The Act:

- gives individuals a legally enforceable right of access to health information about them that is contained in records held in Victoria by the private sector; and
- establishes Health Privacy Principles (HPPs) that will apply to health information collected and handled in Victoria by the Victorian public sector and the private sector.[102]

The HPPs generally apply to:

- all personal information collected in providing a health, mental health, disability, aged care, or palliative care service; and
- all health information held by other organisations

Complaints about interferences with privacy (breaches of Part 5 of the Act or an HPP) are handled by the Health Services Commissioner.

In some states, such as South Australia, there is no dedicated legislation under which the collection, storage, and access to personal health information is regulated, and in others the right to access information legislation extends only to public authorities and Ministers (see Tasmania's *Right to Information Act 2009* and WA's *Freedom of Information Act 1992).*

Table 9.6: State, territory, & federal laws on privacy & access to personal information

Jurisdiction	Act	Regulator	Website
ACT	Health Records (Privacy and Access) Act 1997	Human Rights Commission	www.hrc.act.gov.au/health
NSW	Health Record and Information Privacy Act 2002	Information and Privacy Commission NSW	www.ipc.nsw.gov.au/
NT	Information Act 2002	Northern Territory Information Commissioner	health.nt.gov.au/freedom-of-information
QLD	Right to Information Act 2009 Information Privacy Act 2009	Office of the Information Commissioner	www.oic.qld.gov.au/about/privacy
SA	Freedom of Information Act 1991 Cabinet Administrative Instruction No. 1 of 1989 Part II Information Privacy Principles Instruction	Privacy Committee of South Australia	www.dpc.sa.gov.au/resources-and-publications/premier-and-cabinet-circulars/DPC-Circular-Information-Privacy-Principles-IPPS-Instruction.pdf
TAS	Right to Information Act 2009 Personal Information Protection Act 2004	Ombudsman Tasmania	www.ombudsman.tas.gov.au/right-to-information
VIC	Health Records Act 2001 Freedom of Information Act 1992	Health Complaints Commission Office of the Victorian Information Commissioner	www.health.vic.gov.au/legislation/health-records-act ovic.vic.gov.au/freedom-of-information/make-a-freedom-of-information-request/
WA	Freedom of Information Act 1992	Information Commissioner	www.healthywa.health.wa.gov.au/Articles/A_E/Access-my-WA-Health-medical-records

9.10 REGULATION OF NATUROPATHS AND NATUROPATHIC PRACTICE IN OTHER COUNTRIES

In 2005, the Lin Report provided details of regulation of naturopaths in selected jurisdictions, including the European Union, New Zealand, the United Kingdom, Canada, and the USA.

Since then, two published reports provide an international snapshot of regulatory arrangements for naturopaths and the issues the profession faces in strengthening regulation of its practice.

World Naturopathic Federation 2021 Health Technology Assessment

The World Naturopathic Federation (WNF) Health Technology Assessment (Lloyd et al., 2021) includes the results of a survey of occupational licensing laws for the naturopathy profession across the globe. Three findings from this report are highlighted here.

First, the report finds there is a naturopathic workforce in 108 countries, with 35 countries that enforce statutory regulation of the naturopathic profession and another 17 that have a formal process of voluntary certification (self-regulation). There is variability in the legislative mechanism used to regulate naturopaths – some jurisdictions have enacted a specific licensing law for naturopaths (i.e., Naturopathy Act), others have umbrella legislation governing a cluster of professions that includes naturopaths, either along with other allied health professions or traditional and complementary medicine professions (Lloyd et al., 2021: x, 49). The evidence suggests a growing number of countries have legislated licensing/registration schemes for the naturopathy profession (Lloyde et al., 2021: 36-41).

Second, in some jurisdictions regulatory models other than statutory registration/licensing have been applied to the naturopathy profession. For instance, negative licensing schemes are found in Australia (outlined above) and in the USA (the State of Minnesota). The Minnesota negative licensing scheme predates the Australian schemes and operates in a similar way, although it applies only to unlicensed complementary and alternative health care practitioners (CAP practitioners). The Minnesota legislature has enacted a law creating the Office of Unlicensed Complementary and Alternative Health Care Practice (CAP) within the Minnesota Department of Health (MDH). The role of the Office is to investigate complaints and take enforcement actions against CAP practitioners for violations of prohibited conduct. MDH also provides objective information to consumers about CAP.[103]

Third, co-regulation schemes are found in various jurisdictions, some with a statutory basis. For instance, the United Kingdom's Professional Standards Authority for health and social care (PSA), a statutory regulator, has powers to operate an 'accredited voluntary registers program'.[104] Hong Kong has legislated a similar scheme for its healthcare professionals who are not subject to statutory registration in Hong Kong.[105]

Under the UK Accredited Registers program, the PSA has published minimum standards for the operation of public registers. A professional association that operates

102 See https://www.health.vic.gov.au/legislation/health-records-act

a public register of qualified members may apply to the PSA for accreditation of its register. The association pays a fee to the PSA for the assessment. A practitioner who has met the membership requirements of the association and whose name appears on an accredited register may advertise that fact to the public. When choosing a health service, consumers are encouraged to choose a practitioner who is a member of a PSA accredited register. The PSA has statutory powers to suspend the accreditation of a voluntary registrant, apply conditions, or remove a professional association's accreditation.

Registers that have been accredited by the PSA include:

- ***Complementary and Natural Healthcare Council (CNHC)*** – The CNHC is a voluntary regulator of complementary healthcare practitioners. They were established with Department of Health funding and support and their key purpose is to protect the public.
- ***Federation of Holistic Therapists (FHT)*** – The FHT is a professional association for therapists and has been committed to developing and promoting high standards in therapy training and practice for more than 55 years. It runs the largest Accredited Register of complementary therapists independently approved by the Professional Standards Authority, covering 17 different therapies that can be used safely alongside standard medical care.

The PSA website states that the accreditation of the Society of Homeopaths was withdrawn in 2021.

WHO commissioned review of global health practitioner regulation literature (2024)

A recent World Health Organization (WHO) commissioned study of health practitioner regulation systems worldwide presented findings with respect to regulation of T&CM practitioners – see **Textbox 9.6**.

Textbox 9.6: Findings from World Health Organization commissioned study of health practitioner regulation with respect to traditional & complementary medicine (T&CM)

Statutory registration is being extended to more T&CM occupations in more jurisdictions, in response to evidence of risk.

Statutory registration schemes have been enacted at an accelerating rate for T&CM occupations over the past decade, often to preserve Indigenous medicine traditions in low and or middle-income countries (LMICs) and in response to pressure from representative bodies in high income countries (HIC) s. Some jurisdictions have applied regulatory impact assessment processes to inform decisions about whether and how to regulate these occupations. These studies suggest the risk profile of some T&CM occupations warrants the level of public protection that statutory registration affords.

Statutory registration is a favoured strategy of many T&CM professional bodies to prevent entry of untrained practitioners, foster collaborative practice, and promote integration into the mainstream healthcare systems.

While the literature points to continuing interest in and use of T&CM in LMICs and HICs, studies suggest that T&CM practitioners continue to struggle for institutional recognition of their practice and engage with conventional practitioners in collaborative practice. In LMICs, studies show efforts to better harness Indigenous medicine practitioners to deliver primary care and meet public health goals, with statutory registration a vehicle to lift the status of Indigenous medicine practitioners and facilitate their integration into mainstream health systems. In HICs, occupational closure is sought to lift standards, protect the public, and increase institutional recognition. It may also be pursued to address restrictive regulations that limit practice or prevent access to tools of trade (herbal medicines).

Studies suggest that statutory registration works equally well for established and widely practised T&CM occupations, with some adjustments.

Statutory registration of T&CM occupations has been implemented in both LMICs and HICs. Where such schemes are in operation, studies suggest that this regulatory model works just as well as for other health occupations. A similar range of research concerns was found, such as the content of accreditation standards, implementing evidence-based national examinations, regulatory strengthening, and regulating scopes of practice. Studies note some of the policy challenges and adjustments required when applying statutory registration to the T&CM occupations, such as evaluating risk, protecting traditional knowledge, applying flexible language requirements, or delivering care to underserved populations.

Source: Carlton et al. (2024); Leslie et al. (2023).

103 See Minnesota Department of Health website.
104 Professional Standards Authority for Health and Social Care. What We Do. 2021.
105 See Hong Kong Department of Health.

9.11 DISCUSSION

There is a plethora of laws that affect the practise of naturopathy in Australia. Since 2005, some laws have been amended and others have been repealed and replaced. However, it seems there have been few changes that effectively strengthen public protection or improve the safety and quality of naturopathic practice. Concerns are in four main areas:

- continuing deficiencies in self-regulation
- fragmentation of industry representation
- naturopaths denied access to their tools of trade
- limitations in health complaints mechanisms and consumer protection law

Continuing deficiencies in self-regulation

The deficiencies in self-regulation identified by the Lin Report remain. While there has been a substantial decline in the number of professional associations administering self-regulation (voluntary certification) schemes, there has been no noticeable improvement in the enforcement of minimum qualification and practice standards and varying levels of transparency in the operation of such schemes. If anything, the profession's capacity to enforce minimum qualification standards for entry to the profession has been seriously weakened, by forces beyond its control.

Certain Federal Government policy decisions have seriously undermined the profession's efforts to self-regulate. These decisions include:

- to change the private health insurance rules to remove patient rebates for naturopathic services (see **Chapter 8** of this report)
- to deregulate education by removing naturopathic programs from the Health Training Package and therefore from the jurisdiction of ASQA, without providing any alternative mechanism for enforcing degree level as the minimum standard of training for entry to practice as a naturopath (see **Chapter 6** of this report)
- to recognise the standards of multiple national professional associations for members to qualify to provide GST-free services (see **Chapter 7** of this report).

While the failures associated with implementation of the GST legislation date back to the earlier 2000s, two more recent Australian Government decisions have, in effect, pulled the rug out from under the professions' efforts to self-regulate.

First, the Australian Government's decision to withdraw VET sector accreditation of advanced diploma programs in naturopathy, while justified on public policy grounds (that entry to this profession should be at degree level and therefore accredited by TEQSA not ASQA), has had perverse consequences for the profession and the public. In the absence of government incentives to enforce degree level as the minimum standard, new programs have entered the market that position themselves as similar to advanced diploma level. However, unlike previous advanced diplomas which were accredited by government under the Health Training Package, these new programs are operating without government quality assurance under ASQA and without any other independent quality assurance mechanism.

Naturopaths are independent primary care practitioners who treat patients with a wide range of acute and chronic health conditions. Like other health professions with an equivalent scope of practice, degree level is the appropriate standard for entry to naturopathic practice.

Withdrawing VET sector accreditation of naturopathy programs, even if delivered by Registered Training Organisations (RTOs), while also failing to prevent education providers from continuing to offer programs at less than degree level, has removed an important quality control mechanism for reinforcing community expectations of minimum qualifications for entry to naturopathic practice. Some professional associations have continued to recognise and accept for membership purposes, unaccredited qualifications marketed as diplomas and advanced diplomas, thereby undermining efforts by other associations to enforce AQF 7 (degree level) as the minimum standard for entry to practice.

Second, the Australian Government's decision in 2018 to change the *Private Health Insurance Rules* to prevent private health insurers from providing rebates for recognised providers of naturopathic medicine has removed the single most effective incentive encouraging those entering naturopathic practice to make the effort to obtain an acceptable education qualification. Also, removing this incentive for practitioners to join an association to qualify their patients for private health insurance rebates has reduced the capacity of associations to enforce compliance with a variety of practice standards including CPD, codes of practice, insurance, as well as the loss of an avenue for dealing with consumer complaints of poor practice.

As discussed in **Chapter 7** of this report, ARONAH was established in 2010 in an attempt to regulate the naturopathy and WHM professions. Unlike professional associations, the mandate of ARONAH is to regulate the professions rather than to represent and promote the interests of its members. However, without strong external government and other institutional incentives for practitioners to submit their credentials for assessment and join the ARONAH Register, very few practitioners have taken this step.

This is not surprising. Apart from each practitioner's personal commitment to the highest professional standards, there are few other incentives.

106 See the website of the Federation of Naturopathic Medicine Regulatory Authorities (FNMRA) for a list of the US States and Canadian Provinces that license naturopathic physicians and naturopaths.

Naturopathy is arguably the largest and most popular primary care complementary therapy available in Australia. People with no qualifications, or those with qualifications unrelated to naturopathy who are disposed to flout industry, professional, and community norms are able to enter naturopathic practice and advertise their services to the public.

We know that this is happening – see **Chapter 3** for recent egregious cases of serious harm to patients from unqualified or underqualified persons entering the profession. These cases are troubling – for the patients who have suffered harm, and for reputable and concerned naturopaths and herbalists who see the consequences for their profession and feel powerless to do anything to prevent this. The data presented in this report, combined with the earlier studies documented in the Lin Report, suggest a pattern of harms that is not being addressed.

Since 2005 there has been a substantial reduction in the number of professional associations that represent naturopaths. However, fragmentation of industry representation remains, with five peak professional associations who have positioned themselves to represent the naturopathy/WHM professions nationally, only two of which are recognised by the WNF (because the majority of their members are naturopaths). It is likely to be challenging for the naturopathy/WHM professions to achieve strong representation and advocate effectively for their interests with this level of fragmentation, nor can its self-regulatory functions work effectively to enforce minimum standards to protect the public.

The limitations of voluntary certification are well documented: conflicts of interest within professional associations, inadequate sanctioning of members when warranted, under-enforcement of compliance to standards, and reduced accountability of associations, education providers, and practitioners (Freiberg 2017: 113-114; Lloyd et al., 2021: 50-51).

This continued fragmentation of the profession and lack of effective mechanisms to enforce minimum qualification and practice standards for the naturopathy/WHM professions is enabled by failures of government policy.

Naturopaths denied access to their tools of trade

Little has changed with respect to the access of naturopaths to their tools of trade. As Lin & colleagues found, the scheduling system for naturopathic medicines under state and territory drugs and poisons laws continues to operate in a way that denies access for competent naturopaths to their tools of trade. There is also no effective system for regulation of the quality and safety of raw herbs intended for extemporaneous dispensing (2005: 282).

Limited effectiveness of health complaints mechanisms and consumer protection laws

There have been some changes to regulations in this area since 2005, notably the extension of powers of health complaints commissioners in some states, to enable prohibition orders to be issued to remove unfit health care workers from the workforce. Complaints about the professional conduct of practitioners may be lodged with state and territory health complaints commissioners. However, as outlined in **Chapter 3**, there are two main deficiencies in powers to deal with persons who claim to be naturopaths but who are unqualified, under-qualified, or otherwise unfit to practise.

First, implementation of the prohibition order powers has been slow. Western Australia and ACT implemented the arrangements only in 2023 and in two jurisdictions (Tas and NT), the National Code of Conduct for health care workers has not yet been implemented, despite eight years since all state and territory Health Ministers (sitting as the COAG Health Council) agreed to implement schemes within their jurisdictions (COAG Health Council, 2015).

In jurisdictions without a statutory code of conduct and prohibition order powers, the ability of Commissioners to deal with poor practitioner conduct relies on the receptivity of the practitioner (except for criminal conduct which may be referred to the police) (Lin et al., 2005: 283). Failure to legislate to extend the commissioners' powers (as in Northern Territory), or to commence the legislated powers (as in Tasmania) means these health complaints commissioners have no powers to issue a prohibition order to remove an incompetent or dangerous practitioner from the health workforce. **Chapter 3** highlights a pattern of harm, over an extended period, from practitioners who call themselves naturopaths but who have little or no qualifications to practise.

Second, while four out of eight health complaints commissioners have a statutory code of conduct for non-registered health care workers and prohibition order powers to remove unfit persons from the health workforce, these powers generally come into play only after a patient has suffered harm. The prohibition order powers of health complaints commissioners are principally exercised downstream, when harms have already occurred, rather than upstream, where regulatory intervention might prevent harms occurring in the first place. For every patient who is prepared to lodge a complaint, there are likely to be others who have been similarly harmed but do not have the personal resources to do so.

With respect to general consumer protection laws, while there is now a nationally consistent legislative framework for consumer protection, no evidence was identified that it has been used to protect consumers of naturopathic services or that the avenues for dealing with

unqualified or unfit naturopaths are being more widely used. Consistent with the findings of Lin & colleagues, consumer protection laws and the common law provide some protections to the public where information about products or services is false and misleading, goods sold are not fit for the purposes intended, or the practitioner has been negligent, however, litigation is stressful and expensive, and its outcomes can be unpredictable (2005: 282-83).

9.12 CONCLUSIONS

It is now 20 years since the Lin Report identified the need for governments to put in place effective patient protection measures for the substantial segment of the population who use the services of a naturopath or herbalist. Since then, government policy changes, particularly at the federal level (in accreditation of education and private health insurance rules), have undermined and compromised the professions' efforts to self-regulate, to the detriment of health consumers.

Many governments elsewhere have recognised the need to support patient choice and safety by strengthening the regulation of naturopaths and herbalists. Many jurisdictions have introduced statutory registration for the profession, including at least 24 US States and six Canadian Provinces.[106] Once a leader in regulation of complementary therapies, Australia is now lagging.

While the occupational regulatory arrangements, which rely principally on self-regulation and negative licensing, go some way to protecting the public, these quality assurance mechanisms are inadequate, given the pattern of harm identified in this report.

For instance, the COVID-19 pandemic has drawn attention to cases where untrained or poorly trained naturopaths have acted in ways that have undermined important public health messaging about infection control and vaccination. There is a need for governments to engage naturopaths in the development of public health messaging, to ensure accurate information is provided to their patients. Exclusion of naturopaths and their representative bodies from mainstream service provider networks and government consultations is not tenable in the current climate. The risks are too great.

Patients have the right to choose naturopathic care and in doing so, should not be exposed to unnecessary risks because governments have removed the co-regulatory mechanisms that were working to promote quality of care and keep them safe.

Failure to develop explicit policies concerning this workforce is contrary to WHO policy on traditional and complementary medicine (WHO 2013). As a matter of priority, state, territory and federal governments should:

- re-visit the policy changes that have undermined self-regulation of naturopaths and herbalists, and
- re-examine the case for statutory registration of naturopathy and WHM.

10
ASSESSING THE NEED FOR STRONGER REGULATION OF THE NATUROPATHY AND WESTERN HERBAL MEDICINE PROFESSIONS

Anne-Louise Carlton

10.1 INTRODUCTION

Every year, a sizeable segment of Australian consumers makes an informed choice when managing their health care – to use the services of a naturopath or herbalist. They most likely attend a naturopath or herbalist who is in independent private practice and offers primary care services to treat a range of acute and chronic health conditions, across the entire lifespan. They often use naturopathy or WHM alongside other conventional medical and health services (Casey et al., 2008; Murthy et al., 2014; McIntyre et al., 2019).

When making such health care decisions, Australian consumers have the right to reasonable assurance that the naturopath or herbalist they choose is properly trained and regulated, to the same standard generally expected of any primary care practitioner with a similarly broad (and risky) scope of practice.

This chapter brings together the research evidence reported in Chapters 1-9 of this report to inform an assessment of the naturopathy and WHM professions against the regulatory assessment criteria published by the Australian Health Ministers' Advisory Council (AHMAC, 2018). The suitability of various alternative models for regulation of the naturopathy profession is discussed and whether continuing the status quo (no change in regulation) is a satisfactory option. The chapter concludes with recommendations directed at Australian state, territory, and federal governments concerning the type of regulation considered necessary to assure the Australian community of the quality and safety of naturopaths and herbalists.

10.2 BACKGROUND TO THE AHMAC REGULATORY ASSESSMENT CRITERIA AND PROCESS

The regulatory assessment policy framework

The policy framework that guides the assessment by governments of the need to extend statutory registration to additional health professions is set out in three key documents.

First, the *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the health professions* (the NRAS IGA), signed in 2008 by Australian state, territory, and federal governments. This agreement committed all governments to the establishment of NRAS.

The NRAS was established for 14 professions in 2010-12 and the scheme was expanded in 2018 to include the profession of paramedicine and regulate midwifery as a separate profession (making 16 regulated health professions encompassing 24 health occupations,[107] regulated by 15 National Boards).

Attachment B of the NRAS IGA sets out the arrangements for inclusion of other health professions in the National Scheme and adopts the AHMAC criteria for regulatory assessment that were first agreed upon by state, territory, and federal governments in 1995 – see Textbox 10.1.

107 For example, dental is counted as a single regulated profession but includes the following occupational groups: dentists, dental therapists, dental hygienists, dental prosthetists and oral health therapists.

Textbox 10.1: The AHMAC criteria for regulatory assessment of the need for statutory registration of a health profession

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?
2. Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?
3. Do existing regulatory or other mechanisms fail to address health and safety issues?
4. Is regulation possible to implement for the occupation in question?
5. Is regulation practical to implement for the occupation in question?
6. Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

Source: AHMAC, 1995; COAG, 2008; AHMAC, 2018

The NRAS IGA references two 'guiding principles' in applying these criteria:

> ***(a) the sole purpose of registration is to protect the public interest; and***
>
> ***(b) the purpose of registration is not to protect the interests of health occupations.***

Second, in 2018 AHMAC published a document titled *AHMAC information on regulatory assessment criteria and process for adding new professions to the National Registration and Accreditation Scheme for the health professions* (the AHMAC Guidance).

The AHMAC Guidance outlines the process to be followed by the NRAS Ministerial Council (comprising all state, territory, and federal Health Ministers) when deciding whether to extend the scope of the NRAS to include a non-registered health profession. The document:

- describes how the NRAS Ministerial Council (formerly known as the COAG Health Council or CHC) considers submissions
- details the six 'threshold criteria' from the NRAS IGA that a profession must meet to be considered for regulation under the NRAS, and
- sets out a two-stage assessment process which includes assessment against the six AHMAC criteria as well as a regulatory impact assessment (RIA).

The AHMAC Guidance notes that statutory registration is one of several types of regulation governing health workers in Australia and can be restrictive and costly compared with other forms of regulation that may provide similar benefits at lower cost to the community (AHMAC 2018: 5). These other forms of regulation include:

- self-regulation
- negative licensing
- protection of title
- credentialling
- various forms of co-regulation (AHMAC 2018: 5)

Chapter 9 provides a description of these types of occupational regulation.

Third, in 2023 an updated document titled Regulatory Impact Analysis Guide for Ministers' Meetings and National Standard Setting Bodies (the RIA Guide) was published on the website of the Australian Government Department of Prime Minister and Cabinet's Office of Impact Analysis. This document sets out the Impact Analysis requirements for any decisions taken by inter-governmental decision-making bodies (such as Ministerial Councils) to introduce new regulation. The RIA Guide is to be applied whenever the Ministerial Council is considering amending the National Law to change the scope and operation of the NRAS.

The regulatory assessment process

The AHMAC criteria have not changed since they were first agreed upon in 1995 (AHMAC, 1995; COAG, 2008; AHMAC, 2018). However, the assessment process has been revised to include a further hurdle – that the regulatory impact assessment process complies with the requirements set out in the RIA Guide (2023).

While decisions to extend statutory registration to a currently unregistered health profession are subject to national agreement, it appears that a state or territory government may choose to 'go it alone' and regulate a health profession outside of the NRAS, with or without securing the prior agreement or blessing of the NRAS Ministerial Council. A recent example is the passage through the South Australian Parliament of legislation to establish a registration scheme in that state for the profession of Social Work.[108]

108 See the Social Workers Registration Act 2021 (SA). At the time of writing this scheme is yet to commence.

10.3 ASSESSMENT AGAINST THE AHMAC CRITERIA

In accordance with the AHMAC Guidance of 2018, an assessment of the professions of naturopathy and WHM against the AHMAC Criteria is presented below.

Criterion 1 – Is it appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation fall more appropriately within the domain of another Ministry?

Naturopathy and WHM are health professions:

- the services provided by naturopaths and herbalists fall within the statutory definition of a 'health service' contained in health complaints legislation in each state and territory
- the tools of trade of naturopaths and herbalists (herbal medicines) are regulated by the Therapeutic Goods Administration under the Australian Government Department of Health and Ageing
- consumer complaints about naturopaths and herbalists fall within the jurisdiction of health complaints commissioners in each state and territory

Responsibility for policy decisions concerning occupational regulation of the professions of naturopathy and WHM properly sits within the health portfolios of state, territory, and/or federal Health Ministers:

- Naturopaths and herbalists deliver health care services to the Australian public. Consumers seek the services of naturopaths and herbalists as primary contact practitioners, for health advice, both for therapeutic purposes and for the maintenance of health and wellbeing.
- Consumer use of naturopathic and herbalist services in parallel with biomedicine medicine is well-established in all age groups. This dual usage can continue over a prolonged time because many users are treated for chronic illnesses or are using naturopathy/WHM products to deal with the effects of other medical treatments for serious health conditions.
- Naturopathic and herbal medicines and other products are governed by a suite of laws that sit within the portfolios of state, territory, and federal Health Ministers. These include therapeutic goods and medicines laws, health complaints laws, and infection control standards under public health legislation.
- Although the advertising and sale of naturopathic and herbal medicines and products are covered under fair trading and trade practices legislation, this is the same for the products and services provided by other regulated health practitioners.

There are no other ministerial portfolios at either state/territory or federal level that have responsibility for regulation of naturopaths and herbalists.

Conclusion regarding Criterion 1:

It is **appropriate for Health Ministers to exercise responsibility** for determining the regulatory requirements for naturopaths and herbalists and regulating naturopathic/WHM practice. Naturopathy and WHM are health professions that sit within the health portfolio. These professions do not more appropriately sit within the portfolio 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?

Naturopaths and herbalists are primary care practitioners who work autonomously, principally in solo or group private practices (Steel et al., 2020). The practise of naturopathy and WHM is broad in scope and presents a range of risks of varying significance. The literature provides extensive references on the risks associated with naturopathic and WHM practice (Lloyd et al., 2021; Weir, 2016; Lin et al., 2005).

These risks can be categorised as follows:

- risks associated with the treatments used by naturopaths and herbalists
- risks associated with the scope of practice of naturopaths and herbalists
- risks associated with the practice context

Table 3.2 provides an overview of the main risks to public health and safety. As outlined in Chapter 3, these risks are not just theoretical – there are documented case examples where these risks have been realised in practice in Australia.

Risks associated with treatment modalities used by naturopaths and herbalists

Risks associated with the treatment modalities used by naturopaths and herbalists fall into two categories:

- risks associated with the exercise of clinical judgement by the naturopath or herbalist
- risks that arise from the consumption of nutritional and herbal medicines

The chart below shows the exponential growth in published research from a single database (Ovid MEDLINE) on adverse effects using general herb and supplement terms (see Figure 10.1).

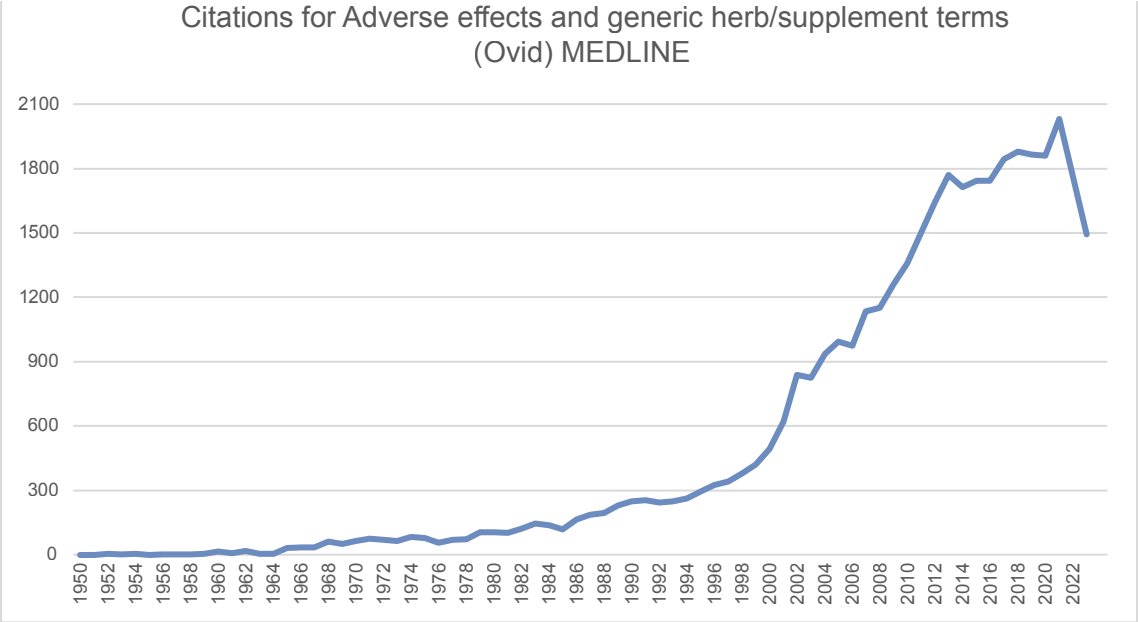

Figure 10.1: Results of bibliometric analysis of adverse effects & 'herb'/'supplement' terms

As outlined in Chapter 3, the findings of Lin & colleagues (2005: 30-34) are supported with updated data from key sources (Lloyd et al., 2021: 71-78):

- Cases of adverse events related to acts of commission (such as recommending cessation of medical treatment or failure to avoid known interactions with pharmaceuticals) and acts of omission (such as misdiagnosis and failure to refer on to an appropriate practitioner) have been reported in the literature and in the media. Although these events do not appear to be widespread, the COVID-19 pandemic has highlighted cases and the potentially serious consequences.
- Like conventional pharmaceutical medicines, herbal medicines can produce predictable and unpredictable effects. Examples of both have been identified in the literature. Predictable effects include direct toxicity, toxicity related to overdose of a preparation, and interaction with pharmaceutical medicines. Unpredictable effects include allergic and anaphylactic reactions to herbal medicines, and idiosyncratic reactions (Colalto 2012; WH 2004).
- Several herbs and supplements are known to cause toxic reactions and while severely toxic substances are restricted by current drugs and poisons legislation, several potentially toxic substances continue to be available to naturopaths for use in prescriptions (Asif 2012; Brown 2017; Brown 2018; Posadzki et al., 2013).
- Herbal medicines have potential to interact with pharmaceutical drugs (Gurley et al., 2012), and numerous cases of such herb-drug interactions have been reported (Myers & Cheras 2004; Izzo & Ernst 2009).

The level of risk identified is likely to be underestimated because:

- there appears to be significant under-reporting to government agencies of adverse events associated with nutritional and herbal medicines, due in part to the lack of awareness of the appropriate avenues for such reporting
- some practitioners are likely to be fearful that reporting adverse events may result in withdrawal of access to medicines
- the ADRS database administered by the TGA is limited in its usefulness with respect to complementary medicines
- complaints data held by professional associations are largely about professional issues rather than adverse reactions to medicines (2005: 292)

Also, the risk profile of the naturopathy and WHM professions is increasing due to factors such as:

- the use of naturopathic/herbal medicines for a wider range of illnesses
- concurrent use of pharmaceutical medicines along with herbal medicines and nutritional supplements (Morgan et al., 2012)

- the development of manufacturing techniques that alter the potency of products
- the accessibility of products from overseas suppliers with unknown manufacturing standards and product authentication processes (2005: 46-7, 292)
- loss of government incentives for naturopaths and herbalists to participate in voluntary certification (loss of private health insurance rebates for naturopathic treatments; removal of naturopathic education programs from the Health Training Package)

Risks associated with the scope of practice of naturopaths and herbalists

As outlined in Chapter 5, naturopaths and herbalists are primary care practitioners who provide diagnostic and treatment services under a paradigm that differs from that of conventional biomedicine. They have a very broad scope of practice – they see patients from every demographic and treat a wide range of health conditions, including patients with potentially life-threatening illnesses. They do this without the need for a referral from a medical practitioner.

Health practitioners with similarly broad scopes of practice, such as medical practitioners, nurses and Chinese medicine practitioners are all subject to statutory registration under the NRAS.

Applying the risk framework used by governments to assess the need for occupational regulation of the health professions, the scopes of practice for naturopaths and herbalists typically include at least **eight (8)** of these activities. This is high compared with most regulated health professions, where the range is between three high risk activities (optometrists, pharmacists, and psychologists) and 13 (medical practitioners). Only five regulated professions have a higher risk rating than naturopaths and herbalists. They are medical practice (13), nursing and midwifery (10), paramedicine (10) and Chinese medicine (10).

Every naturopath and herbalist has a professional obligation to recognise the limits of their practice and to refer on to other practitioners, including medical practitioners, when the needs of the patient dictate. This is an important part of their ethical and clinical training.

Harms occur when a naturopath or herbalist fails in their exercise of clinical judgement, either through acts of commission or omission. These risks relate to incorrect, inadequate, or delayed diagnosis, or failure to make timely referrals to practitioners who are best placed to treat the patient. These risks increase when the naturopath or herbalist has received insufficient clinical and ethical training to recognise the limits of their practice and make appropriate referrals.

Table 3.5 includes a selection of high-profile cases where naturopaths and herbalists have been prosecuted for offences ranging from sexual assault to making dubious treatment claims and misrepresenting their qualifications to advising their patients to cease conventional medical treatments. All very serious matters. Many of these cases involve individuals who have had insufficient training and would not be eligible to practise naturopathy or WHM if minimum entry level qualification and probity standards were enforced.

Risks associated with the practice context

When compared with other regulated health professions, there are four main contextual factors that increase the comparative risks associated with naturopathic or WHM practice:

- the absence of effective controls over entry to practice as a naturopath/WHM practitioner
- the difficulties for patients in identifying who is properly qualified and in good standing as a naturopath/herbalist
- the challenges for patients of navigating two systems of medicine, particularly for those who use naturopathy or WHM in conjunction with conventional biomedicine
- the absence of quality controls exercised through employers, public sector work settings, and third-party payment systems (health insurers)

First, with the lack of effective controls over entry-to-practise as a naturopath or herbalist, any person can set up practice without qualifications or probity checking. There is no enforced minimum entry level qualification, no minimum standard of education necessary for clinical practise as a naturopath or herbalist, and no checking to ensure the person is of good character prior to their commencing practice.

This heightens the risk to service users because, as outlined above, naturopaths and herbalists have a very broad scope of practice, treating patients with a wide range of health conditions, using treatment modalities that carry inherent risks. Also:

- naturopaths and herbalists do not have access to the range of diagnostic tools that are available to practitioners of conventional medicine
- untrained or undertrained persons are less likely to recognise the limits of their skills and knowledge and to refer on appropriately
- misdiagnosis is more likely if clinical training hours are inadequate or there is inadequate exposure during training to a range of patients and health conditions
- there is a lack of training and guidelines on the clinical management of patients who use naturopathic/herbal medicines in conjunction with pharmaceutical drugs

The data presented in Chapter 3 shows a pattern of harms associated with those who seize the opportunity to 'make a quick buck', choosing to flout professional norms by establishing themselves in practice without industry recognised qualifications. Anecdotal evidence suggests such practitioners are predisposed to disregard other ethical norms and standards of professional practice. Recent cases demonstrate this problem – unqualified persons who pretend to be qualified have used the opportunities presented by their practice as a naturopath or herbalist to breach the trust of their patients by committing sexual assault (see Table 3.5).

The media coverage of these cases reports these people as 'naturopaths', because that is the title they have assumed for themselves. However, the reality is that most are not qualified naturopaths – they may have done short courses, may have no qualifications at all, or have been deregistered from a health profession regulated under the NRAS. They have traded on the reputation of and trust in the naturopathy and WHM professions to exploit vulnerable patients.

Second, compounding these problems, there is no single trusted source of information for prospective patients about who is qualified as a naturopath or herbalist and in good standing in their profession. Instead, there are multiple and competing professional associations, all of which claim to represent qualified naturopaths and herbalists but set different qualification standards for membership and provide different levels of service to members and to the public. This adds to the confusion for prospective patients.

This multitude of professional bodies with their varying standards exacerbates the information asymmetry so that the average consumer is likely to struggle to know who is properly qualified as a naturopath or herbalist and who is not.

Third, unlike many of the allied health professions:

- most naturopaths and herbalists are self-employed and work in independent private practice rather than for large employers (Steel et al., 2020)
- naturopaths and herbalists are not generally employed in the publicly funded health services where governments have a role in setting standards, via funding arrangements and/or policy directions
- the services provided by naturopaths and herbalists are not reimbursable under Australia's universal health insurance scheme or by other third-party payers such as for veteran's health services, workers compensation, and traffic accident schemes
- the services provided by naturopaths and herbalists have not been reimbursable by private health insurance funds since this entitlement was removed in 2019[109]

The quality controls that usually apply in group settings (employment contracts, clinical governance systems, risk audit, performance appraisal etc) are absent. Also, with the removal of naturopathy and WHM services from the eligibility for rebates under the Australian Government's Private Health Insurance Rules, there are no institutional quality control measures applied by third-party payers, that is, no public and private health insurers who scrutinise claims data and may alert regulators to professional practice or clinical governance failures.

Fourth, for those who use both naturopathy or WHM and conventional medical practitioners, there are heightened risks associated with herb/drug interactions. These risks are exacerbated by a general lack of communication among the various providers and the lack of training and guidance for practitioners on the clinical management of patients who use naturopathic and other herbal medicines in conjunction with pharmaceutical drugs. As more people with chronic health conditions choose naturopathic or WHM treatment, the potential for herb/drug interactions increases. Compounding this problem, there is evidence that many patients do not tell their treating medical practitioners of their use of naturopathic/herbal medicines:

The Lin Report found:

- the majority of patients self-refer following recommendation from another person
- treatment is sought for a wide range of physical and psychological problems, and management is multifaceted (including lifestyle advice, nutritional supplements, herbal medicines, and exercise)
- those seeking naturopathic/WHM care frequently do so for chronic conditions, which means they are likely to be frequent and routine users
- approximately half of the profiled patients had previously consulted a medical practitioner (general or specialist) for their complaints before visiting a naturopath, but communication between practitioners occurred in only a minority of cases
- among the profiled patients receiving naturopathic treatment, over one third were also taking pharmaceutical drugs
- poor communication between medical and complementary medicine practitioners can have dangerous consequences in terms of drug interactions and delayed diagnosis (2005: 294)

More recent data suggest these risks remain and are being compounded by the variability in education and training of naturopaths and herbalists (see Chapter 6). Those who enter practice with inadequate or no qualifications and clinical training are less likely to have the capacity or motivation to keep up to date with the exponential growth in naturopathic/WHM research, they are less likely to be engaged with their peers in scholarly collaboration, or to adopt evidence-based naturopathic/WHM practice.

109 See Natural Therapies Review.

Conclusion regarding Criterion 2:

The treatment modalities, scope of practice, and practice context of naturopaths and herbalists all contribute to **a risk profile for the unregulated naturopathy and WHM professions** that is **unacceptably high** and on par with or greater than many of the health professions that are subject to statutory registration. These risks are not just theoretical – the data shows there is a pattern of harm, with repeated cases over three decades.

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

Naturopaths and herbalists are subject to a range of laws and regulations at federal, state and local government levels (see Chapter 9). Taken together, these laws present a complex and confusing array of mechanisms for assuring the quality of naturopathic services and protecting public health and safety. While responsibilities are shared across a range of regulators, there are significant gaps and deficiencies. Unlike the NRAS for the registered health professions, there is no single regulator that has sufficient powers to effectively mitigate these risks.

The failures are in four areas:

- failure of self-regulation
- failure of co-regulation
- limitations of negative licensing (code regulation)
- lack of access for naturopaths to some of their tools of trade

Failure of self-regulation

Self-regulation describes the various certification schemes operated by member based professional associations. Such schemes (also referred to as 'voluntary certification') generally comprise the following elements:

- a professional association with a constitution and/or bylaws that set out the rules of the association
- a board of directors constituted with persons elected by members of the association
- published membership requirements that include:
  - a recognised minimum qualification for practising membership
  - agreement to comply with a Code of Conduct and standards of practice set by the association
- a process for assessing and approving qualifying education programs for membership eligibility purposes
- operation of a publicly accessible web-based searchable register enabling the public to locate qualified practising members who are in good standing with the association
- policies and processes for receiving and investigating complaints about members and dealing with any misconduct
- by-laws that enable removal of membership from those who breach the Code of Conduct

Effective certification schemes are operating for many unregistered allied health professions – see for example Speech Pathology Australia, the Dietitians Australia, and the Australian Association of Social Workers (AASW). However, the politics at play mean the naturopathy and WHM professions are ultimately incapable of achieving the unified institutional representation that is needed to achieve effective self-regulation, to the detriment of patients. Given the risk profiles of naturopathy and WHM professions (see Criterion 2), relying on self-regulation to protect the public from harm has proved to be inadequate (see Chapters 3 & 10).

The WHO has periodically called for Member States to regulate T&CM practitioners and practice. The WHO Global TM Strategy titled *WHO Traditional Medicine Strategy 2014-2023* identified a range of challenges facing Member States in regulating the T&CM workforce (WHO 2014: 40). The Strategy encourages member states to strengthen quality assurance, safety, proper use and effectiveness of T&CM by regulating products, practices, and practitioners (WHO 2013: 45).

The 2021 WNF Health Technology Assessment investigated occupational regulation regimes across 108 countries (Lloyd et al., 2021). Researchers concluded that reliance on voluntary certification is problematic when the practices of a health profession present potentially serious risks to public health and safety:

- Where there are no statutory powers to restrict entry to a profession, those with minimal or no qualifications can set up practice and use the titles of the profession without meeting acceptable minimum standards of training and practice. This has led to widely varying standards of practice and levels of qualifications, substantial fragmentation of these professions, and no widely recognised and accepted peak bodies (Lloyd et al., 2021: 50).
- Most professional associations rely on volunteers drawn from the profession who may lack access to the necessary skills, resources, and capacity to handle the complexity associated with effective regulation (Lloyd et al., 2021: 50).
- There are conflicts of interest in the operation of voluntary certification which can compromise public protection, for example where the professional association is responsible for representing its members' interests and at the same time accrediting

programs that are tied to membership and dealing with complaints about members.

- Schemes that operate at arms-length from professional associations (such as the model adopted in Australia by ARONAH) are often constrained by poor resourcing and policy capacity and as with all voluntary certification, the standards apply only to those practitioners who choose to opt in (Lloyd et al., 2021: 50).

Reliance on professional associations to effectively manage complaints is problematic. Successive studies of complaint management systems show:

- Unlike complaints and disciplinary systems operated by statutory bodies, there is little transparency or accountability and little published information about the procedures followed or the outcomes achieved (see Chapter 6).
- In many cases, those managing the disciplinary processes lack experience in matters of procedural fairness (2005: 297).
- Most complaints management systems have limited or no avenues of appeal and, most importantly, lack teeth – naturopaths who are the subject of investigation have been known to let their membership lapse to avoid disciplinary action.

Many of the more egregious cases described in Table 3.5 appear as isolated individual failures. However, they reflect a pattern of harms linked to a broader institutional failure that has been confronting the naturopathic and WHM professions for decades.

In response, the profession has made efforts to 'get its house in order'. Over 30 years, some of the better resourced professional associations have endeavoured to develop a uniform and effective model of self-regulation, however these efforts have been largely unsuccessful (Dean et al, 2002; Lin et al., 2005: 296). Textbox 10.2 lists some of these initiatives.

However, without strong and consistent institutional support from professional associations, education institutions, employer bodies, insurers, and governments, voluntary certification schemes generally lack sufficient incentives for practitioners to participate, and efforts to deal with non-compliance are generally ineffective (Lloyd et al., 2022: 50). Efforts have been hampered by the fragmented representative arrangements, the ongoing disagreement amongst professional associations about the entry level qualifications required for safe and competent practice, and lack of government leadership and support.

Textbox 10.2: Profession-led self-regulation initiatives – 1991-2023

1991 – the Federation of Natural and Traditional Therapists (FNTT) is established as an umbrella body comprising multiple professional associations.

2003 – the NHAA proposes the establishment of a single national Complementary Medicine Registration Board to advise each state and territory government and implement harmonised legislation across Australia for naturopaths and Western herbalists (Dean et al., 2002).

2003 – the Complementary Medicine Practitioner Associations Council (CMPAC) is established by ANTA and ATMS in response to an ATO requirement for practitioner membership of a national "register" to qualify for GST exemption for naturopathic consultations.

2010 – the Australian Register of Naturopaths and Herbalists (ARONAH) is established as an independent voluntary regulatory body to ensure minimum standards for naturopathy and WHM in Australia that mirrors government requirements for the regulation of health practitioners.

2019 – the Australian Naturopathic Council (ANC) is established as a coordinating council representing naturopathic organisations who are members of the WNF and have a shared vision for the advancement of naturopathy in Australia. The ANC is one united body that represents Australian naturopathic practitioners in relation to lobbying, statutory registration, and policy formation and interpretation.

2022 – the Australian Naturopathic Council (ANC) publishes a paper for consultation, in the form of a draft submission to Australian governments, proposing statutory registration for the naturopathy profession and inviting naturopathy and WHM professional associations to join deliberations.

While there has been a significant reduction in the number of professional associations that represent naturopaths since 2005, this consolidation has failed to achieve the unified voice on professional standards, education, and practice that is needed for effective profession-led self-regulation (see Chapter 7).

See Textbox 10.3 on the ARONAH experience of voluntary certification.

Textbox 10.3: The Australian Register of Naturopaths and Herbalists – efforts to establish a self-regulatory scheme and voluntary register for naturopaths & herbalists

- In July 2013, the Australian Register of Naturopaths and Herbalists was officially opened for registration.
- Since then, practitioners have been encouraged to join the voluntary register through articles published in practitioner journals and social media.
- ARONAH has struggled to build a solid registrant base over the last 10 years and while there have been new registrants each year, just as many do not re-register.
- Reasons given by practitioners not re-registering include:
  - Unwilling to increase insurance cover to levels required for registration
  - Change in views regarding registration since COVID-19 pandemic
  - No perceived benefit from registration
  - Not happy with ARONAH
  - Non-payment
  - Financial reasons
  - Retired from practice or no longer practising

Source: ARONAH 2022

If it were simply a matter of the profession redoubling its efforts, then it would be reasonable for governments to expect more from the profession. However, it is wrong to assume that these failures result from of lack of capability or effort on the part of the profession. Instead, they reflect broader institutional failures associated with the power dynamics at play within and beyond the profession – a lack of authoritative guidance, support, and recognition from governments and other institutions such as insurers and employers.

Similar challenges were faced by the Chinese medicine profession in the 1990s in its efforts at self-regulation – a substantial and increasing risk profile, fragmented professional representation, inability to achieve broad consensus within the profession on minimum standards of training for entry to practice (despite successive efforts), and lack of broader institutional reinforcement of self-regulation (Victorian Government, Department of Human Services, 1998). In that case the Victorian Government recognised the need to intervene in the public interest and legislated to establish the first registration scheme for the Chinese medicine profession in Australia (Carlton 2017: 186-202).

Failure of co-regulation

Governments play an important role in reinforcing and supporting professional association led practitioner certification schemes, principally by providing incentives that encourage practitioners to participate in and comply with certification requirements.

For instance, by tying access to recognised provider status under various government health insurance schemes (Medicare, Veterans Health, traffic accident, and workers compensation) with participation in a professional association led certification scheme, governments have established powerful incentives for allied health practitioners to join such certification schemes and comply with the standards set. Other examples of co-regulation include:

- the Australian Government's Private Health Insurance Rules[110] which determine what types of health services are eligible for patient rebates paid by private health insurers
- the Australian Government Department of Home Affairs (Immigration and Citizenship) recognition of some allied health professional associations as assessing authorities for the purpose of assessing the qualifications of applicants for skilled migration[111].

However, unlike in the UK[112] where a strong co-regulatory scheme operates for the unregulated health professions, Australian governments have missed several important opportunities to use the levers of co-regulation to establish or reinforce unified national qualification and practice standards for the naturopathy and WHM professions.

Australian governments provide few incentives for naturopaths and herbalists to submit to voluntary certification with a peak professional association. To complicate matters, governments recognise the standards of multiple associations, thereby undermining any efforts to achieve uniform national standards. Since publication of the Lin Report, several opportunities have been missed for governments to implement a common minimum qualification standard for entry to practice. In fact, standards have deteriorated with the Federal Government's withdrawal of two important mechanisms previously relied upon by professional associations to set and reinforce minimum qualification and practice standards for naturopaths:

- the removal in 2019 of eligibility of naturopaths and herbalists for provider rebate status with private health funds – see Textbox 8.1 and
- the withdrawal in 2016 of the VET sector accreditations of naturopathic and WHM qualifications and training providers[113] – see Textbox 8.2.

110 See Australian Government Private Health Insurance Rules.
111 The Dept of Home Affairs website indicates that the Australian Association of Social Workers, Dietitians Australia and Speech Pathology Australia are the professional associations authorised to assess overseas practitioners for skilled migration purposes. See https://immi.homeaffairs.gov.au/visas/working-in-australia/skills-assessment/assessing-authorities
112 The United Kingdom Government operates a co-regulatory scheme in the form of its Voluntary Registers Program.
113 Withdrawn after December 2015 with teach out till the end of 2018. See 'Advanced Diplomas to be deleted'.

Similarly, the Lin Report was critical of earlier decisions by the ATO – for recognising, for GST purposes, multiple sets of standards for multiple professional associations. Recognition of multiple professional associations means that a practitioner found to have breached the standards of one association can join another association that has national standards and maintain their GST-free status as a 'recognised professional' (2005: 257). The effect of these changes has been to undermine efforts by professional associations to set and enforce minimum qualification and practice standards. See Textbox 9.4 (GST Tax arrangements).

The limitations of negative licensing (the code of conduct and prohibition order powers)

There is evidence that increasing numbers of consumers are lodging complaints with state and territory health complaints commissioners and in some instances, Commissioners have taken action against so-called 'naturopaths', including by issuing prohibition orders (Doolan 2024).

A negative licensing or 'code regulation' scheme is now in operation in six Australian states (Australian Capital Territory, New South Wales, Queensland, South Australia, Victoria and Western Australia) but at the time of writing it is yet to be implemented in Tasmania or the Northern Territory.[114]

The six schemes operate in broadly the same way – see Textbox 10.3.

In 2020 amendments to the NSW scheme extended the powers of the NSW Health Care Complaints Commission to cover health organisations, as well as individual practitioners,[115] and in September 2022, the NSW *Public Health Regulation 2022* was amended to introduce a *Code of Conduct for health organisations*.[116]

While the NSW changes are a welcome development, there are some deficiencies in these arrangements which, when considered in light of the risk profiles of the naturopathy and WHM professions, raise concerns about the adequacy of the protections afforded consumers and the effectiveness of this mechanism in the absence of other controls over professional practice.

First, the threshold for regulatory action by a complaints commissioner is generally 'serious risk to public health or safety' or commission of a serious criminal offence, that is, an offence punishable by imprisonment. This is a very high threshold for regulatory action. As a consequence, only the most egregious cases result in regulatory action and a prohibition order (Lloyd et al., 2021: 51). Presumably if a complaint is not suitable for conciliation, it is closed without further action.

Second, these code of conduct and prohibition order powers have been implemented in only six out of eight states and territories. In the remaining jurisdictions, there is no statutory code and no powers to issue prohibition orders even in the most egregious cases – see Table 3.5.

Third, given the harms that have been reported, complaints mechanisms appear to be underutilised, in some cases lacking in transparency and are not standardised across jurisdictions. The level of information available to the public concerning prohibition orders issued under the six schemes is highly variable. For example, in Victoria, virtually no information is published on the website of the Health Complaints Commissioner when a prohibition order or interim prohibition order is published. It is questionable how members of the public are protected from practitioners who are unfit to practise if the most basic information about the nature of the misconduct that led to the prohibition order remains confidential.

A recent study of the operation of these negative licensing schemes (Doolan 2024) has found inconsistencies and gaps in the way the state and territory HCE schemes operate:

- There is no standardisation in the reporting of complaints data across the jurisdictions, so it is difficult to compare the schemes against the most basic of performance indicators such as number of complaints received per year by occupational group, nature of complaints, outcomes, number of prohibition orders issued etc. For example, while NSW provides an annual breakdown of complaints against types of unregistered health practitioners, Queensland and Victoria do not.
- In NSW prohibition orders may be removed once they have expired whereas in Queensland ('Qld') prohibition orders may be removed if the Health Ombudsman ('HO') or the Queensland Civil and Administrative Tribunal ('QCAT') revokes the prohibition order. This means the numbers of prohibition orders reported in the NSW Health Care Complaints Commission ('HCCC') and Qld Office of the HO (OHO) Annual Reports do not accord with those available on their websites.
- Unlike the NRAS:
  - there is no link or permanent record of disciplinary decisions provided to the public for unregistered health practitioners, and
  - there is no national register of prohibition orders available for the public to easily search to check unregistered practitioner qualifications or details.
- Information available on the type of practitioner issued with prohibition orders is variable, with a lack of adequate description on the Queensland and Victorian websites.
- Many of the prohibition orders provide no detail or reasons why a prohibition order was made.

Fourth, the use of the prohibition order powers is largely reactive, with regulatory action triggered usually once harm has already occurred (Lloyd et al., 2021: 51). Such schemes do not provide the infrastructure to enable

114 As outlined in Chapter 10, a national agreement signed by all state, territory, and federal governments in 2015 committed every state and territory to implement the scheme in accordance with a nationally agreed policy framework. See Victorian Department of Health on behalf of the Australian Health Ministers' Advisory Council, Final Report A National Code of Conduct for health care workers. 2015.
115 See Health Legislation (Miscellaneous Amendments) Act 2020 (NSW)
116 See NSW Code of Conduct for health organisations.

proactive and non-punitive quality assurance measures to be applied. Minimum levels of practitioner training and probity checks are not enforceable, nor are education programs to assist practitioners to identify and prevent inappropriate practice behaviours – measures that would be expected to prevent recidivism and reduce the risk of breaches by other practitioners (Lloyd et al., 2021: 51).

One Health Complaints Commissioner has reported on some of the deficiencies:

> ***In the absence of the ability to identify all classes of unregistered practitioners or to know how many are in each class, communicating clearly to consumers and providers about who is regulated and who is not is difficult. Planning and effective regulation is also a significant challenge… defined and consistent treatment standards or protocols are often not in place… evidence gathering throughout investigations may be more difficult and resource intensive (NSW HCCC 2019: 33).***

A recent study found the proportion of complaints that result in a prohibition order removing the practitioner from practice appears to be higher for unregistered practitioners under code regulation in NSW compared with removals (cancellation or suspension of registration) for practitioners under the NRAS (Doolan 2024). The NSW HCCC has stated that these investigations *'tend to raise serious concerns of public health and safety and generate intensive and complex investigations'* (NSW HCCC 2020: 55).

This finding suggests that while the prohibition order powers may be serving an important public protection function, stronger regulation with a preventive focus may be warranted.

Lack of access for naturopaths to their tools of the trade

The current system of restricting access to toxic herbs via the Standard for Uniform Scheduling of Medicines and Poisons (SUSMP) means competent naturopaths are denied access to some important herbs used in naturopathic treatment. The effect of these scheduling arrangements places a range of herbal medicine products out of reach of those practitioners who are trained to use them.

It is a perverse outcome of the scheduling arrangements that only registered medical practitioners (for schedule 4 medicines) and pharmacists (for schedule 2 and 3 medicines) are authorised to prescribe these herbal medicines, but without the necessary training to do so safely and competently.

Conclusion regarding Criterion 3:

The **risk profiles of the naturopathy and WHM professions are substantial** and there is a pattern of harm to consumers that is not being adequately addressed under current regulatory arrangements.

The existing mix of self-regulatory, co-regulatory, negative licensing, and other mechanisms are failing to adequately address the risks of harm associated with unregulated naturopathic and WHM practice.

Without enforceable controls over entry to practice in the profession, there are no effective mechanisms to enforce minimum practice standards and no effective methods of preventing unqualified individuals from continuing to practice. People who have no qualifications whatsoever, those who been expelled from a professional association for misconduct, and those deregistered from other regulated professions, cannot be prevented from entering practise as a naturopath or herbalist.

The institutional failures outlined here reflect the broader power relations embedded within the Australian healthcare system that maintain the marginalised position of the naturopathy and WHM professions. Attitudinal barriers mean that naturopaths and herbalists are excluded from many mainstream healthcare settings and benefits, making it difficult to influence government policy decisions that affect their interests.

The end result is that consumers are more exposed and vulnerable to fly-by-night opportunists who lack proper naturopathic or WHM qualifications and are disposed to flout professional norms and exploit the trust and vulnerabilities of their patients for personal gain.

Existing regulatory mechanisms are failing to deal with this fundamental problem.

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

Naturopathy and WHM are well-defined and widely practised health professions in Australia. This is evidenced by the following:

First, the Australian and New Zealand Standard Classification of Occupations (ANZSCO) designates naturopathy as occupational Skill level 1, bachelor's degree or higher:

> ***252213 NATUROPATH***
>
> ***Treats internal health problems, metabolic disorders and imbalances through treatment of the***

whole person using natural therapies. Registration or licensing may be required.

Skill Level: 1[117]

This is equivalent to other health occupations such as dentists, general practitioners, nurses, optometrists, and pharmacists.

Second, the naturopathy and WHM professions have a well-established body of knowledge, with education programs for naturopaths and herbalists for entry to practice that have been offered at tertiary level in Australia for over five decades. Naturopathy/WHM curricula have been developed at bachelor's degree level and offered by several universities.

Until 2018, the boundaries of the practice of naturopathy and WHM were defined via the VET sector Health Training Package, with broad agreement on core competencies and curriculum requirements. Since then, standards for accreditation of education programs in both naturopathy and WHM have been published by ARONAH.[118]

In 2022, ARONAH issued updated Competency Standards for Naturopathic Practitioners and Competency Standards for Western herbalists, following an extended consultation with the profession and key stakeholders.[119]

Third, the WHO has issued benchmarks for training in naturopathy to ensure practice meets minimum levels of adequate knowledge, skills, and awareness of indications and contraindications (WHO, 2010: viii). The WHO Western Pacific Region has issued guidance on how Member States may strengthen occupational regulation of the health workforce, including the T&CM professions (WHO WPR, 2016; 2019).

Fourth, the WNF has issued a Naturopathic Educational Program Guide to promote accreditation of naturopathic educational programs and the highest educational standards for the naturopathic profession globally (WNF, 2022).

It is therefore possible to define the profession and its body of knowledge sufficiently for the purposes of regulation.

Conclusion regarding Criterion 4:

Regulation is possible to implement for the **naturopathy and WHM** professions – they are **well-defined and well-established health professions in Australia**. They have an established body of knowledge, modalities, principles and philosophies, and established education and practice standards.

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

There are established precedents for statutory registration of naturopaths and herbalists. These professions are recognised and regulated in many other jurisdictions, including the USA and Canada (Lloyd et al., 2021).

There are also precedents for registration of T&CM professions in Australia (osteopathy, chiropractic and Chinese medicine), including where the use of ingestive medicines (herbal medicines) are a core component of the scope of practice. Chinese medicine has been successfully regulated under a protection of title model, first in Victoria from 2000 and then nationally since 2012.

The Lin Report documented some of the practical challenges faced by the Chinese Medicine Registration Board of Victoria when establishing the registration scheme, including:

- setting the registration fee – given the actual number of practitioners and the number likely to be granted registration were unknown
- conducting the 'grandparenting' process – particularly assessing the competence of existing practitioners who had low level qualifications but who had undertaken multiple additional short courses and whose clinical training was limited
- setting appropriate standards for education – by defining learning outcomes (rather than specifying curricula design) and by allowing institutions time to upgrade their programs
- educating the profession, private health funds, and the public about the role of the regulator and distinguishing this from the role of professional associations
- aligning standards for practice with other registration boards (2005: 300)

While similar practical issues would be expected to arise with registration of naturopaths and herbalists, these are not insurmountable, and the number of potential registrants would be expected to be considerably higher than for Chinese medicine, providing the economies of scale necessary to keep registration fees relatively low.

Four out of five professional representative bodies support statutory registration for the naturopathy and WHM professions and surveys of practitioners have consistently shown that a majority are supportive of registration and are willing and able to finance and support a self-funded National Board.

117 See ANZSCO.
118 See ARONAH website www.aronah.org/course-accreditation/
119 See ARONAH.

Conclusion regarding Criterion 5:

Regulation is practical to implement for the naturopathy and WHM professions. Introduction of statutory registration is not without some practical challenges. However, experiences in other jurisdictions and with the implementation of national registration of the Chinese medicine profession shows that these **challenges are solvable**, and this experience can be drawn upon in implementing appropriate arrangements for the naturopathy and WHM professions.

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

A Regulation Impact Statement (RIS) would be expected to assess several options for occupational regulation of naturopaths and herbalists, including:

- professional association run registers with member certification – the status quo (no change)
- supporting self-regulation through co-regulatory partnerships with government – for example, via a quality assured voluntary registers scheme
- strengthening negative licensing – state and territory codes of conduct with powers to issue enforceable prohibition orders
- statutory registration – under the NRAS

Table 10.7 compares each main type of occupational regulation against a list of key features and capabilities.

Table 10.7: Types of occupational regulation and key features/capabilities

	Type of occupational regulation			
Key feature/capability	Professional association certification – self-regulation	Co-regulation	Negative licensing	Occupational licensing/ statutory registration
Statutory basis	No	Maybe	Yes	Yes
Enforceable minimum qualifications for entry to practice	No	No	No	Yes
Probity checking of persons prior to entry to practice	No	No	No	Yes
Accreditation of qualifying programs for entry to practice	Yes	Maybe	No	Yes
Enforceable minimum standards of practice	No	No	Yes	Yes
Mandatory continuing professional development (CPD)	Yes (for members)	Maybe	No	Yes
Obligation to report professional misconduct by fellow practitioners	No	No	Yes	Yes
Powers to monitor practitioner compliance with practice standards	No	No	No	Yes
Powers to impose conditions or limitations on a practitioner's practice	No	No	Yes	Yes
Power to issue practice guidelines/codes	Yes	No	No	Yes
Complaints and disciplinary powers	Yes (for members only)	Maybe	Yes	Yes
Powers to remove unfit practitioners from practice	No	No	Yes	Yes
Offences and penalties for unauthorised use of professional titles	No	No	No	Yes
A publicly accessible register of qualified practitioners	Maybe	Maybe	No	Yes
A publicly accessible register of disqualified or barred practitioners	No	No	Yes	Yes
Publication of disciplinary decisions	No	No	Yes	Yes
Protection from civil liability for board members discharging regulatory functions	No	No	Yes	Yes

The preferred option – statutory registration of the naturopathy profession under the NRAS.

Some naturopathy practices pose a significant risk of harm, and these risks are compounded by the primary healthcare context and the broad scope of practice of naturopaths. Existing regulatory mechanisms are inadequate for safeguarding and protecting consumers. There are definable modalities, an established scope of practice, and body of knowledge for which it is possible to implement regulation. There are some practical challenges, but implementation lessons can be drawn from the experience of introducing statutory registration for the Chinese medicine profession in 2012 and more recently the paramedicine profession in 2018. The benefits of protecting public health and safety through statutory registration are considered to outweigh the potential adverse effects.

Anticipated costs of registration

Registration fees vary with the size of the profession – smaller professions have higher fees because there are fewer economies of scale.

Assuming a registrant base of approximately 15,000 naturopaths, it is estimated that the fee for general registration would be in the order of $300-$350 per annum per registrant, although this figure would be expected to reduce after the first few years, once sufficient financial reserves of the new National Board had been built up.

This figure has been arrived at based on the following assumptions:

- Naturopathy and WHM would be regulated under a single National Board, with divisions of the register and protected titles for each profession;
- The combined number of registrants would be roughly equivalent to a medium sized profession, much larger than the registered professions of chiropractic, osteopathy, and Chinese medicine but smaller than medical radiation and paramedics;
- The fee charged for general registration in 2022 for other similar sized professions:[120]

Profession	Registrant base (2020-21)	General registration fee (2022)
Medical radiation practice	21,844	$203
Paramedicine	21,492	$240
Chiropractic	5,968	$530
Chinese medicine	4,863	$579 (one division)

Source: Ahpra/National Boards Annual Report 2020/21 and Ahpra website

- While there are some complexities with regulating the naturopathy and WHM professions due principally to the use of ingestive medicines, it is expected these professions would be less costly to regulate than the Chinese medicine profession or chiropractic. This is because of the greater economies of scale (naturopathy is approximately three times the size of these two professions), most naturopaths and herbalists are trained in Australia, and grandparenting would likely be less complex because of the decades long history of accreditation of education programs, and there would unlikely be the language translation costs that are faced by the Chinese Medicine Board.

Anticipated benefits of statutory registration

Statutory registration is warranted given the scopes of practice of naturopaths and herbalists, the risks associated with their practice, and the range of harms to the public that arise from uncontrolled entry to these professions. There are risks associated with the use of ingestive medicines which are exacerbated if practitioners are not properly trained about indications, contraindications, and the interactions between naturopathic/herbal medicines and pharmaceutical drugs.

Existing regulatory arrangements are insufficient to protect the public from unqualified or under-qualified practitioners. A pattern of harm has been established over at least three decades, harm that has proven unresponsive to existing regulatory mechanisms.

The code of conduct and prohibition order powers of health complaints commissioners in six states (negative licensing) provide insufficient public protection because commissioners are generally alerted only after a patient has suffered harm. These powers do not prevent unethical persons from setting up practice where they see an opportunity to make money by exploiting vulnerable patients. The cases presented in this study show a pattern of harm that is likely to continue without stronger controls over entry to the profession.

Statutory registration would provide more robust and effective complaints and disciplinary processes. Under statutory registration, the regulation and representative functions of professional associations would be separated, thereby reducing the possibility of conflicts of interest. Professional associations would be able to focus their resources on support of their members and professional development. The public would have greater trust and confidence that the profession is properly regulated and accountable.

120 For general registration fees for 2022-23 for each regulated health profession, see here. For registrant numbers see the Ahpra/National Boards Annual Report for 2020-21.

Conclusion regarding Criterion 6:

This report provides prima facie evidence of the need for statutory registration for the naturopathy and WHM professions and that the substantial benefits of regulation are expected to outweigh the costs. This assessment demonstrates that existing mechanisms for protecting the public are inadequate and that statutory registration is the only option that will provide sufficient protection from harm, given the risk profile of these professions.

10.4 CONCLUSIONS AND RECOMMENDATIONS

In accordance with the AHMAC Guidance (2018), it is concluded that a prima face case is made for statutory registration of the professions of naturopathy and WHM.

Governments are urged to allocate the resources required to undertake an RIA process to assess the case for statutory registration of the naturopathy and WHM professions.

GLOSSARY OF TERMS

Complementary and alternative medicine (CAM) – a broad set of health care practices that are not part of the country's own tradition and are not integrated into the dominant health care system (WHO 2008: 1). A broad range of therapeutic interventions developed and practiced by trained healthcare professionals and disciplines who have created bodies of knowledge that are used for education and training (Gaboury et al., 2012: 5). The range of therapeutics that largely originate from traditions and theories distinct from contemporary biomedical science, and which claim mechanisms of action outside of those currently accepted by scientific and biomedical consensus (Garrett et al., 2022: 1168). A group of diverse medical and health care systems, practices, and products that are not presently considered to be part of conventional medicine, as defined by medical peers (Kotsirilos 2005: 595).

Complementary medicine (CM) – the terms 'complementary medicine' or 'alternative medicine' refer to a broad set of health care practices that are not part of that country's own traditional or conventional medicine and are not fully integrated into the dominant health-care system. These terms are used interchangeably with traditional medicine in some countries (WHO 2013: 15).

Healthcare worker – used here to describe a person who delivers preventive, curative, health promotion, or rehabilitative healthcare services either directly, such as doctors and nurses, or indirectly such as aides, laboratory technicians, patient transport officers, or clinical waste handlers. They work in a range of settings like hospitals, healthcare centres, and other service delivery settings as well as in academic training, research, and administration. They may or may not be subject to a licensing regime.

Health workforce regulation – used here to describe the subset of a country's laws and regulations that apply specifically to occupations, that is, health professions, occupations and health care workers some of whom may not identify with any particular profession. Health workforce regulation includes occupational licensing law and other non-statutory forms of regulation, such as bylaws and rules of association enacted by non-statutory standard setting bodies such as professional associations representing health professions. The term is often used interchangeably with 'occupational regulation'.

Herbalist – used interchangeably with the term Western herbal medicine practitioner.

Naturopath – used here to describe a health practitioner who has:

- completed core training in naturopathic principles, history, theories and philosophy, and in at least three of five practice modalities: (i) herbal medicine; (ii) clinical nutrition; (iii) applied nutrition; (iv) manual therapies; and (v) exercise therapy; and
- achieved the competencies as described in the Australian Register of Naturopaths and Herbalists (ARONAH) *Competency Standards for Naturopathic Practitioners*.[121]

The qualifications for entry to practice as a naturopath would generally be at AQF Level 7 or equivalent with provision for the grandparenting of practitioners with historic qualifications who can demonstrate a record of safe practice.

While the modalities encompassed by naturopathy also may be practised as single modalities, this study does not encompass those practitioners whose training and practice is in a single modality of massage, clinical nutrition (sometimes called 'nutritional medicine'), homeopathy, or counselling.

Profession – used here to describe a class of practitioner that is subject to regulation under a country's licensing laws. Where there are multiple sub-groups regulated in a sector – for example in dentistry or pharmacy, where there are dental nurses and pharmacy assistants as well as dentists and pharmacists – then these sub-groups are referred to as 'occupational groups' within a profession.

Occupational licensing – used here to describe a form of licensing where the qualifications, character, and other credentials of a health practitioner are assessed, their name is placed on a public register (usually web-based), and they are legally authorised to practise in a regulated health profession and/or use a reserved professional title. In some countries this is called 'registration' or 'statutory registration'. Under some licensing laws, a process of both registration (the first entry of the person's name on the public register) and licensing (issuing of an annual practising certificate) is required. It is distinguished from other licensing schemes in health in that the licensee is an individual practitioner rather than a business or a medicine and the license affords the person certain rights to practise.

Regulator – used here to describe the entity that exercises the statutory functions to register and regulate health practitioners in a country. The regulator may be a government department, a committee or board established by government, or a statutory authority established as a separate legal entity and operating at arms-length from government.

Traditional medicine (TM) – traditional medicine has a long history. It is the sum total of the knowledge, skill, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement, or treatment of physical and mental illness (WHO 2013: 15).

Traditional and complementary medicine (T&CM) – used here to describe broad range of disciplines with varied medical philosophies, diagnostic methods, therapeutic interventions, and lifestyle approaches that are grouped

121 Noting there is not yet broad consensus among professional associations and education providers concerning Australian competency standards for naturopaths, this report references the Australian Competency Standards for Naturopathic Practitioners, published by ARONAH. See ARONAH website: www.aronah.org/wp-content/uploads/ARONAH_Competency-standards_Naturopaths.pdf

collectively because they are in some way dissimilar to health care that is offered by the prevailing healthcare system (Chatfield 2018: 1). T&CM merges the terms TM and CM, encompassing products, practices, and practitioners (WHO 2013: 15).

Western herbal medicine – used here to describe a clinical practice of healing using naturally occurring plant material or plants with little or no industrial processing. Medicines or extracts from crude plant material, such as root, bark, and flower, are used in multiple plant formulations to treat persons with disease and dysfunction and to promote health and well-being. WHM is a term recently used to differentiate herbalism based on Anglo-American traditional herbal medicine from other systems of herbal medicine such as Ayurveda or traditional Chinese Medicine (Niemeyer 2013: 1-2).

Western herbal medicine practitioner – used here to describe a person who provides health services that involve the extemporaneous compounding of herbs for therapeutic purposes for individuals under their care, and

- has satisfactorily completed core training in herbal medicine principles, history, theories, philosophy and practice; and
- has achieved the competencies set out in ARONAH's Competency Standards for Western herbalists.[122]

The qualifications for entry to practice as a WHM practitioner would generally be at AQF Level 7 or equivalent with provision for grandparenting of practitioners with historic qualifications who can demonstrate a record of safe practice.

122 Noting there is not yet broad consensus among professional associations and education providers concerning Australian competency standards for Western herbalists, this report references the Australian Competency Standards for Western Herbalists, published by ARONAH. See ARONAH website: https://www.aronah.org/wp-content/uploads/ARONAH_Competency-standards_Herbalists.pdf.

ACRONYMS

AASW	Australian Association of Social Workers
ABC	Australian Broadcasting Commission
ABS	Australian Bureau of Statistics
ACCC	Australian Competition and Consumer Commission
ACCM	Advisory Committee on Complementary Medicines
ACL	Australian Consumer Law
ACMS	Advisory Committee on Medicines Scheduling
ACNT	Australasian College of Natural Therapies
ACT	Australian Capital Territory
AHHA	Australian Healthcare & Hospitals Association
AHMAC	Australian Health Ministers' Advisory Council
AHPA	Allied Health Professions Australia
AIMA	Australasian Integrative Medicine Association
Ahpra	Australian Health Practitioner Regulation Agency
AM	alternative medicine
AMA	Australian Medical Association
ANC	Australian Naturopathic Council
ANPA	Australian Naturopathic Practitioners Association
ANTA	Australian Natural Therapies Association
ANZSCO	Australian and New Zealand Standard Classification of Occupations
APHA	Australian Private Hospitals Association
ARC	Australian Research Council
ARCCIM	Australian Research Consortium in Complementary and Integrative Medicine
ARGCM	Australian regulatory guidelines for complementary medicine
ARGT	Australian Register of Therapeutic Goods
ARONAH	Australian Register of Naturopaths and Herbalists
ATMS	Australian Traditional Medicine Society
ATO	Australian Taxation Office
CAM	Complementary and alternative medicine
CAP	Office of Unlicensed Complementary and Alternative Health Care Practice (State of Minnesota USA)
CATAG	Council of Australian Therapeutic Advisory Groups
CCA	Competition and Consumer Act 2010 (Cth)
CM	complementary medicine
CMA	Complementary Medicine Association
CMEC	Complementary Medicines Evaluation Committee
CMPAC	Complementary Medicine Practitioner Associations Council
CNHC	Complementary and Natural Healthcare Council (UK)
COAG	Council of Australian Governments
CPD	Continuing professional development
Cth	Commonwealth
DHS	Department of Health Victoria
FHT	Federation of Holistic Therapists (UK)
GP	General practitioner
GST	Goods and Services Tax
HCC	Health Complaints Commissioner (Victoria)
HCCC	Health Care Complaints Commission (NSW)
HCE	Health Complaints Entity
HCEF	Health Chief Executives' Forum
HE	higher education
HTP	Health Training Package
IGA	intergovernmental agreement
IM	integrative medicine
NASRHP	National Alliance of Self Regulating Health Professions
NCCAM	US National Institutes of Health National Centre for Complementary and Alternative Medicine
NDPSC	National Drugs and Poisons Schedule Committee (Therapeutic Goods Administration, Commonwealth Department of Health and Ageing)
NHAA	Naturopaths and Herbalists Association of Australia
NHMRC	National Health and Medical Research Council

NICM HRI	National Institute of Complementary Medicine Health Research Institute, Western Sydney University
NSW	New South Wales
NT	Northern Territory
NRAS	National Registration and Accreditation Scheme for the health professions
OBPR	Office of Best Practice Regulation, Australian Government Department of Prime Minister and Cabinet
OHO	Office of the Health Ombudsman (Queensland)
PBS	Pharmaceutical Benefits Scheme
PHHA	Public Health Association of Australia
PMS	premenstrual syndrome
PRACI	Practitioner Research and Collaboration Initiative
PSA	Professional Standards Authority for Health and Social Care (United Kingdom)
QLD	Queensland
RACGP	Royal Australian College of General Practitioners
RIA	Regulatory impact analysis
RTO	Registered Training Organisation
RACGP	Royal Australian College of General Practitioners
RMIT	Royal Melbourne Institute of Technology University
SCHN	Sydney Children's Hospitals Network
SCU	Southern Cross University
SSNT	Southern School of Natural Therapies
SUSMP	Standard for Uniform Scheduling of Medicines and Poisons
TEQSA	Tertiary Education Quality and Standards Agency
T&CM	Traditional and complementary medicine
TGA	Therapeutic Goods Administration, Australian Government Department of Health and Ageing
TM	Traditional medicine
VET	Vocational education and training
VIC	Victoria
WA	Western Australia
WHM	Western herbal medicine
WHO	World Health Organization
WHO WPR	World Health Organization Western Pacific Region
WNF	World Naturopathic Federation

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APPENDICES

APPENDIX 1.1: Key events and decisions in the history of Australian regulatory policy on regulation of the naturopathic profession

Date	Event
1985	Northern Territory introduces registration of the naturopathic profession with enactment of the *Allied Health Professions Registration Act 1985* (NT).
1992	Northern Territory repeals the *Allied Health Professions Registration Act* and abolishes registration of the naturopathic profession.
July 1998	Report of Victorian Ministerial Advisory Committee on Traditional Chinese Medicine recommends 'That further work be done to establish whether there is a need for statutory registration of practitioners of Western herbal medicine and that this include examination of mechanisms to allow prescribing and dispensing of scheduled Western herbal medicines by suitably qualified practitioners' (Victorian Department of Human Services 1998: 50).
December 1998	Report of the NSW Parliament Committee on the Health Care Complaints Commission 'recommends that the Minister for Health examine the feasibility of establishing umbrella legislation to cover unregistered health care practitioners which establishes a generic form of registration, generic complaint and disciplinary mechanisms, a uniform code of ethical conduct, entry criteria agreed amongst the relevant professions...' (NSW Parliament Legislative Assembly, Committee on the Health Care Complaints Commission 1998: 60).
September 2003	Report of Australian Government's Expert Committee on Complementary Medicines in the Health System released – recommends Health Ministers review the findings of the current New South Wales and Victorian reviews concerning regulation of complementary healthcare practitioners and move quickly to implement statutory regulation where appropriate.' (Commonwealth of Australia Department of Health, Expert Committee Report 2003: 129).
November 2005	Research Report commissioned by Victorian Government Department of Human Services finds statutory regulation of naturopaths and Western herbal medicine practitioners is warranted (Lin et al., 2005).
November 2005	Report of the Committee on the Health Care Complaints Commission released – Chairman's Foreword 'Only formal registration ensures uniformity of professional standards and effective disciplinary processes. Health care complaint handling and registration go hand in hand. This is true for all complementary medicine providers who are currently unregistered... In light of recent concerns that have been highlighted during the course of this inquiry about other areas of unregistered complementary medicine, the Committee intends to revisit its previous report Unregistered Health Practitioners...' (NSW Parliament, Committee on the HCCC November 2005: xi, xii).
December 2005	Report of Productivity Commission *Australia's Health Workforce* recommends establishment of a National Registration and Accreditation scheme for the health professions (Australian Government Productivity Commission 2005: 127).
September 2006	Report of the NSW Parliament Committee on the Health Care Complaints Committee 'recommends the progress of Victoria in relation to the regulation of practitioners of naturopathy and Western herbal medicine be monitored, with the view to further exploring the possible registration of these practitioners in NSW' (NSW Parliament Committee on Health Care Complaints Commission Report 2006: 82).
October 2006	National Herbalists Association of Australia (NHAA) makes a submission to the Victorian Department of Human Services seeking implementation of the recommendations of the Lin Report (2005) (NHAA 2006).
March 2008	Intergovernmental Agreement signed by the Council of Australian Governments, setting out the criteria that are to be applied to assess submissions for expansion of the NRAS to include additional health professions (COAG 2008: 22).
October 2008	Naturopaths for Registration Group makes submission to the Australian Health Ministers' Advisory Council seeking statutory registration for naturopaths (Naturopaths for Registration 2008).
June 2009	South Australian Parliamentary Inquiry Into Bogus, Unregistered and Deregistered Practitioners recommends negative licensing in SA but identified counsellors and naturopaths which required greater regulatory oversight (30th Report of the Social Development Committee June 2009).
July 2010	NRAS commences with national registration for 10 health professions, including chiropractic and osteopathy.
July 2012	Registration commences under the NRAS for four additional professions, one of which is the Chinese medicine profession which includes Chinese herbal medicine practitioners, acupuncturists and herbal dispensers.
April 2013	*Final Report on Options for the Regulation of Unregistered Health Practitioners released,* concludes 'a single National Code of Conduct with enforcement powers for breach of the Code is considered likely to deliver the greatest net public benefit to the community.' (AHMAC 2013: 7).
April 2015	COAG Health Council 'agreed to the terms of the first National Code of Conduct for health care workers ... and to a policy framework to underpin nationally consistent implementation of the Code...' (COAG Health Council *Communique* 17 April 2015: 1).
November 2015	COAG Health Council agrees to amend the National Law to include the profession of paramedicine in the NRAS (COAG Health Council 2015)
September 2016	Australian Natural Therapists Association (ANTA) lodges a submission to the Health Workforce Principal Committee of AHMAC seeking statutory registration for the naturopathy, Western herbal medicine and nutritional medicine professions (Weir 2016).
September 2018	AHMAC publishes guidance on the regulatory assessment criteria and process for adding new professions to the NRAS (AHMAC 2018).
October 2020	The ANC commissions research and preparation of a submission to build upon and update the 2005 Lin Report (ANC 2020).
November 2022	The ANC releases a draft AHMAC submission for public consultation with the naturopathy profession (ANC 2022).

APPENDIX 2.7: Summary table of research articles reporting results from studies examining the prevalence and characteristics of users of naturopathy and WHM services in Australia (n=31)

Author (date)	Title	Study location	Setting	Study design	Profession definition	Sample population	Sample size	Categories of Results: Prevalence	Characteristics	Motivations	Experience of care
Adams et al. (2013)	Complementary and alternative medicine consultations in urban and nonurban areas: A national survey of 1427 Australian women	National	Other: ALSWH	Survey, cross-sectional	Naturopathy/ Herbal medicine	Middle-aged women (45-50 years)	1427	✗			
Bowman et al. (2016)	The characteristics of women using different forms of botanical medicines to manage pregnancy-related health conditions: A preliminary cross-sectional analysis	National	Other: ALSWH	Survey, cross-sectional	Naturopathy/ Herbal medicine	Women who identify as pregnant or recently given birth	1835		✗		
Braun et al. (2010)	Perceptions, use and attitudes of pharmacy customers on complementary medicines and pharmacy practice	Metropolitan Melbourne, Gold Coast region, Wagga Wagga	Pharmacy	Survey, cross-sectional	Naturopathy	Pharmacy customers	1121		✗		
Broom et al. (2012)	Back pain amongst mid-age Australian women: A longitudinal analysis of provider use and self-prescribed treatments	National	Other: ALSWH	Survey, longitudinal	Naturopathy/ Herbal medicine	Women (mid-age)	9820	✗			
Caughey et al. (2020)	The use of CAM products, practices and practitioners by long-term endometrial cancer survivors	New South Wales	Clinical								
trial participants	Qualitative, interviews	Naturopath	Women, long-term endometrial cancer survivors	17			✗				
Fisher et al. (2016)	The use of complementary and alternative medicine by 7427 Australian women with cyclic perimenstrual pain and discomfort: A cross-sectional study	National	Other: ALSWH	Survey, cross-sectional	Naturopathy/ Herbal medicine	Women	7427		✗		
Fisher et al. (2018)	Cyclic perimenstrual pain and discomfort and Australian women's associated use of complementary and alternative medicine: A longitudinal study	National	Other: ALSWH	Survey, longitudinal	Naturopathy/ Herbal medicine	Women	9716	✗			
Foley and Steel (2017)	Patient perceptions of patient-centred care, empathy and empowerment in complementary medicine clinical practice: A cross-sectional study	Queensland	Clinic/health service	Survey, cross-sectional	Naturopathy	Patients (naturopathy patients)	252 (77)		✗		✗

Author (date)	Title	Study location	Setting	Study design	Profession definition	Sample population	Sample size	Categories of Results: Prevalence	Characteristics	Motivations	Experience of care
Foley et al. (2020a)	Consultation with complementary medicine practitioners by individuals with chronic conditions: Characteristics and reasons for consultation in Australian clinical settings	National	Clinic/health service	Survey, cross-sectional	Naturopathy	Patients consulting with a naturopath in a community clinic	33	✗	✗	✗	
Foley et al. (2020b)	Perceptions of person-centred care amongst individuals with chronic conditions who consult complementary medicine practitioners	National	Clinic/ health service	Survey, cross-sectional	Naturopathy	Patients visiting with a naturopath in a community clinic	33				✗
Frawley et al. (2016)	Complementary and alternative medicine practitioner use prior to pregnancy predicts use during pregnancy	National	Other: ALSWH	Survey, longitudinal	Naturopathy/ Herbal medicine	Women who identify as pregnant or recently given birth	1835		✗		
Frawley et al. (2017a)	Prevalence and characteristics of complementary and alternative medicine use by Australian children	National	Online	Survey, cross-sectional	Naturopathy/ Herbal medicine	Parents	149	✗			
Frawley et al. (2017b)	Complementary and conventional health-care utilization among young Australian women with urinary incontinence	National	Other: ALSWH	Survey, cross-sectional	Naturopathy/ Herbal medicine	Women with urinary incontinence (2006 and 2009 surveys of Young cohort)	9047 (2006), 8062 (2009)	✗			
Leach et al. (2020)	Expressed demand for health care services in regional South Australia: A cross-sectional study	Other: South Australia	Online	Survey, cross-sectional	Naturopathy	Adults living in regional, remote, very remote SA	3926	✗			
Lucas et al. (2020)	Complementary and alternative medicine use in Australian children with acute respiratory tract infection: A cross-sectional survey of parents	National	Online	Survey, c ross-sectional	Naturopathy	Parents of 0 – 12-year-old children who use CAM and live in Australia	246	✗			✗
Mak et al. (2010)	Complementary and alternative medicine use by osteoporotic patients in Australia (CAMEO-A): A prospective study	Sydney	Clinic/ health service	Survey, cross-sectional	Naturopathy	Individuals visiting an academic osteoporosis clinic	202		✗		

Author (date)	Title	Study location	Setting	Study design	Profession definition	Sample population	Sample size	Categories of Results: Prevalence	Characteristics	Motivations	Experience of care
Malhotra et al. (2020a)	The prevalence and characteristics of complementary medicine use by Australians living with sleep disorders	National	Online	Survey, cross-sectional	Naturopathy	Individuals living with self-reported sleep disorders	2019	✗		✗	
McIntyre et al. (2019)	Consultations with naturopaths and Western herbalists: Prevalence of use and characteristics of users in Australia	National	Online	Survey, cross-sectional	Naturopathy	General population	2019	✗	✗	✗	✗
Murthy et al. (2014)	Consultations with complementary and alternative medicine practitioners amongst wider care options for back pain: a study of a nationally-representative sample of 1,310 Australian women aged 60-65 years	National	Other: ALSWH	Survey, cross-sectional	Naturopathy	Women (60-65 years)	1310		✗		
Ng et al. (2020)	Patterns of health service utilisation among the Australian population with cancer compared with the general population	National	Other: National Health Survey (2011, 2014)	Survey, cross-sectional	Naturopathy	General population – Cancer	13 762 (2011), 12 979 (2014)	✗	✗		
Peng et al. (2015)	Association between consultations with complementary/alternative medicine practitioners and menopause-related symptoms: A cross-sectional study	National	Other: ALSWH	Survey, longitudinal	Naturopathy/ Herbal medicine	Mid-aged women post-menopause	Oopho-rectomy – 1141; hyster-ectomy – 2260; Natural – 6610		✗		
Sibbritt et al. (2010)	Back pain amongst 8,910 young Australian women: a longitudinal analysis of the use of conventional providers, complementary and alternative medicine practitioners and self-prescribed CAM	National	Other: ALSWH	Survey, longitudinal	Naturopathy/ Herbal medicine	Women (28-36 years)	8910		✗		
Steel et al. (2012)	Utilisation of complementary and alternative (CAM) practitioners within maternity care provision: results from a nationally representative cohort study of 1,835 pregnant women	National	Other: ALSWH	Survey, cross-sectional	Naturopathy/ Herbal medicine	Women who identify as pregnant or recently given birth	1835	✗	✗		
Steel et al. (2014a)	Determinants of women consulting with a complementary and alternative medicine practitioner for pregnancy-related health conditions	National	Other: ALSWH	Survey, cross-sectional	Naturopathy/ Herbal medicine	Women who identify as pregnant or recently given birth	1835		✗		

Author (date)	Title	Study location	Setting	Study design	Profession definition	Sample population	Sample size	Categories of Results: Prevalence	Characteristics	Motivations	Experience of care
Steel et al. (2014b)	The influence of complementary and alternative medicine use in pregnancy on labour pain management choices: results from a nationally representative sample of 1,835 women	National	Other: ALSWH	Survey, cross-sectional	Naturopathy/ Herbal medicine	Women who identify as pregnant or recently given birth	1835		✗		
Steel et al. (2016)	The characteristics of women who use hypnotherapy for intrapartum pain management: Preliminary insights from a nationally-representative sample of Australian women	National	Other: ALSWH	Survey, cross-sectional	Naturopathy/ Herbal medicine	Women who identify as pregnant or recently given birth	1835		✗		
Steel et al. (2017)	The Characteristics of Women Who Use Complementary Medicine While Attempting to Conceive: Results from a Nationally Representative Sample of 13,224 Australian Women	National	Other: ALSWH	Survey, longitudinal	Naturopathy/ Herbal medicine	Young cohort (2006, 2009, 2012) Women identified as attempting to conceive	8200 (778 attempting to conceive)	✗	✗		
Steel et al. (2018)	Associations between complementary medicine utilisation and the use of contraceptive methods: Results of a national cross-sectional survey	National	Other: ALSWH	Survey, ross-sectional	Naturopathy/ Herbal medicine	Women (34-39 yrs) – 2012	8009	✗			
Steel et al. (2020)	Complementary medicine use in the Australian population	National	Online	Survey, cross-sectional	Naturopathy	General population	2019	✗			
Tan and Mak (2014)	Complementary and alternative medicine in diabetes (CALMIND) – a prospective study	Sydney	Clinic/ health service	Survey, cross-sectional	Naturopathy	Patients with diabetes	149	✗			
Wardle et al. (2017)	Associations between complementary medicine utilization and influenza/ pneumococcal vaccination: Results of a national cross-sectional survey of 9151 Australian women	National	Other: ALSWH	Survey, cross-sectional	Naturopathy/ Herbal medicine	Mid-aged women (aged 62-67 years; 2013)	9085	✗			

ALSWH: Australian Longitudinal Study on Women's Health.

APPENDIX 2.2: Summary of results on prevalence, users, motivations and reasons for use, and experiences of use of naturopathy/WHM

TABLE 2.1: Summary of results related to the prevalence of naturopathy use

Author (date)	Sample population	Results	
Adams et al. (2013)	Middle-aged women (45-50 years)	Total: 22.9% (n=327) Major cities: 22% Inner regional: 26% Outer regional: 21% Remove/very remote: 19% p=0.2985	
Broom et al. (2012)	Women (mid-age)	Prevalence of consultation with a naturopath: Had back pain – did not seek help (9%) Had back pain – did seek help (14%) Did not have back pain (8%) p<0.001	Sought help for back pain in 2004 and 2007 (17%) Sought help for back pain in 2007 (13%) Sought help for back pain in 2004 (13%) Did not seek help for back pain in 2004 and 2007 (8%) p<0.001
Fisher et al. (2018)	Women	Over a 7-year period, women with endometriosis were more likely to have consulted a naturopath/WHM (OR 1.54, 1.26-1.88) compared to women without endometriosis Women who sometimes (OR 1.23, 1.09-1.40) or often (OR 1.48, 1.27-1.74) experienced PMS were more likely to consult with a naturopath/WHM Women who sometimes had severe period pain were less likely to consult with a naturopath/WHM (OR 0.78, 0.49-0.83)	
Foley et al. (2020a)	Patients consulting with a naturopath in a community clinic	Most commonly, these users reported consulting with their naturopath 5 or more times (56.7%), but a substantial number also reported as first-time visits (16.7%) or having visited two (10.0%) or three (13.3%) times.	
Frawley et al. (2017a)	Parents	30.4% of parents who use CAM consult with a naturopath with their children	
Frawley et al. (2017b)	Women with urinary incontinence (2006 and 2009 surveys of Young cohort)	*Prevalence of consultations with a naturopath* *2009 data* Women without UI: 12% Had UI but did not seek help: 11% Had UI and did seek help: 19% p=0.002	*2006 and 2009 data* Did not have UI in 2006 or 2009: 12% Sought help for UI in 2006: 15% Sought help for UI in 2009: 20% Sought help for UI in 2006 and 2009: 20% p=0.006
Leach et al. (2020)	Adults living in regional, remote or very remote South Australia	6.5% in the past 12 months Median number of consultations in the past 12 months: 2	
Lucas et al. (2020)	Parents of 0 – 12-year-old children who use CAM and live in Australia	Naturopaths: 50.4% General practitioners: 25.6%	
Malhotra et al. (2020a)	Individuals with self-reported sleep disorders	Consultation with a naturopath: Sleep disorder – 13.6% No sleep disorder – 2.1%	
McIntyre et al. (2019) & Steel et al. (2018a)	General population	*In the previous 12 months* Naturopath: 6.2% WHM: 3.8% Both Naturopath and WHM: 2.4% Either Naturopath or WHM: 7.6% Naturopath No. of consultations: 1-2 – 67.5% 3-4 – 19.8% 5-6 – 5.6% More than 6 – 7.1%	*WHM* No. of consultations: 1-2 – 68.4% 3-4 – 18.4% 5-6 – 7.9% More than 6 – 5.3%
Ng et al. (2020)	General population – Cancer	2011-12 Non-cancer population: 1.94% Overall cancer: 2.68% Current cancer: 2.58% Cancer survivor: 2.70%	2014-15 Non-cancer population: 2.12% Overall cancer: 2.66% Current cancer: 2.92% Cancer survivor: 2.61%

TABLE 2.1: Summary of results related to the prevalence of naturopathy use		
Steel et al. (2012)	Women who identified as pregnant or recently given birth	7.2% reported consulting with a naturopath for pregnancy-related health conditions 4.3% reported consulting with a naturopath for pregnancy-related health conditions, 1 or 2 times 1.6% reported consulting with a naturopath for pregnancy-related health conditions, 3 or 4 times 0.8% reported consulting with a naturopath for pregnancy-related health conditions, 5 or 6 times 0.5% reported consulting with a naturopath for pregnancy-related health conditions, 7 or more times
Steel et al. (2017)	Young cohort (2006, 2009, 2012) Women identified as attempting to conceive	17.1% attempting to conceive (12.8% not) (p<0.001) *Likelihood of consulting a naturopath* Odds Ratio 1.61, Adjusted Odds Ratio 1.30, 1.03-1.64, p=0.03 *Likelihood of women attempting a pregnancy consulting a naturopath over a 6-year period* Adjusted Odds Ratio 4.02, 2.33-14.4, p=0.07
Steel et al. (2018b)	Women (34-39 yrs) – 2012	*Prevalence of naturopathic consultation among women who used different contraceptive methods (compared with women not consulting):* Oral contraception – 17.2% (25.0%), p<0.001 Implants – 8.7% (12.9%), p<0.001 Condoms – 28.0% (22.9%), p=0.002 No contraception – 44.7% (38.9%), p=0.001 *Adjusted Likelihood of consulting:* Oral contraception – NS Implants – OR 0.56 (0.33-0.95), p=0.03 Natural contraception – NS Condoms – NS No contraception – OR 1.61 (1.12, 2.32), p=0.01
Tan and Mak (2014)	Patients with diabetes	6% consulted with a naturopath in the past 5 years
Wardle et al. (2017)	Mid-aged women (aged 62-67 years; 2013)	*Prevalence of consultations with a naturopath among women who received a vaccination (compared to those who did not)* Influenza: 49.3% (66.8%), p<0.001 Pneumococcal: 13.2% (18.1%), p=0.001 *Likelihood* Influenza: 0.64 (0.52, 0.79) Pneumococcal: 0.80 (0.60, 1.07)

TABLE 2.2: Summary of results on characteristics of users of naturopathy/WHM services

Author (date)	Sample population	Results	
Braun et al. (2010)	Pharmacy customers	33% reporting having consulted with a naturopath in the previous 12 months. 20% of pharmacy customers had been recommended to take a complementary medicine (CM) by a naturopath/herbalist 23.5% of pharmacy customers who were using CM had been given information about CM from a naturopath	
Fisher et al. (2016)	Women	Women reporting 'sometimes' (OR 1.48; 1.19-1.85) or 'often' (OR 2.12; 162-2.76) having PMS were more like to consult a naturopath.	
Foley and Steel (2017)	Individuals consulting with a naturopath in an academic clinic	*Age* 18-24 yrs: 23.6% 25-34 yrs: 38.2% 35-44 yrs: 20.0% 45-54 yrs: 16.4% 55 yrs+: 1.8%	*Gender* Female: 87.3% Male: 12.7% Other: 0% Educational qualification Less than Year 12: 20.0% Trade/apprenticeship/certificate/diploma: 34.6% University or higher university degree: 45.5%
Foley et al. (2020a)	Individuals consulting with a naturopath in a community clinic	It was less common for naturopathy users with chronic illness to have private health insurance cover for the profession consulted (55.6%) compared with other health professions studied (acupuncture [86.4%], chiropractic [96%], massage [92.7%], osteopathy [90.6%]). Naturopathy users with chronic illness were more likely to report mental health conditions (78.8%, <0.01) and gastrointestinal conditions (30.3%, p=0.043) compared to the other health conditions studied.	
Mak et al. (2010)	Individuals visiting an osteoporosis clinic	6% consulted a naturopath for their bone/joint health	
McIntyre et al. (2019)	General population	*Naturopathy/WHM users (compared to non-users)* Gender Female: 50.0% (51.4%) Male: 50.0% (48.6%) p=0.74 Age 18-29 yrs: 39.9% (24.2%) 30-39 yrs: 22.9% (14.9%) 40-49 yrs: 17.6% (18.0'%) 50-59 yrs: 10.5% (15.5%) 60 + yrs: 9.2% (27.4%) p<0.001 Location Major cities: 77.1% (72.6%) Inner regional: 13.7% (18.7%) Outer regional/remote – 9.2% (8.7%) p=0.31 Level of qualification Less than 12 yrs: 10.5% (16.7%) 12 yrs or equiv: 17.6% (21.1%) Trade/apprentice/cert/dip: 31.4% (34.0%) University degree: 40.5% (28.2%) p=0.01 Employment status Full-time work: 42.5% (30.8%) Part-time work: 27.5% (17.6%) Casual/temporary: 7.8% (6.8%) Looking for work: 7.8% (9.3%) Not in the paid workforce: 14.4% (35.6%) p<0.001 Marital status Never married: 37.9% (28.2%) Married: 39.9% (43.0%) De facto (opposite sex): 7.8% (11.1%) De facto (same sex): 3.3% (1.3%) Separated/widowed/divorced: 11.1% (16.3%) p=0.01 Manage financially It is difficult all the time: 21.6% (21.3%) It is difficult some of the time: 43.8% (37.5%) It is not too bad: 28.1% (35.2%) It is easy: 6.5% (6.1%) p=0.31	*Private health insurance* Yes: 38.6% (51.9%) p=0.001 Health care card Yes: 35.3% (42.1%) p=0.10 *General health status* Excellent: 11.1% (8.4%) Very good: 29.4% (29.6%) Good: 33.3% (31.7%) Fair: 21.6% (21.8%) Poor: 4.6% (8.4%) p=0.42 *Number of chronic illnesses* None: 26.1% (35.6%) 1: 19.6% (22.8%) 2: 17.0% (13.8% 3: 13.7% (8.7%) 4: 7.2% (7.2%) 5 or more: 16.3% (11.8%) p=0.04, v=0.08 *Type of chronic illness diagnosis* Diabetes: 18.3% (7.9%), p<0.001, v=0.10 Cancer: 7.2% (6.5%), Not significant (NS) Cardiovascular: 18.3% (22.3%), NS Musculoskeletal: 16.3% (15.6%), NS Mental health: 43.1% (30.8%), p=0.002, v=0.07 Respiratory: 24.8% (16.9%), p=0.01, v=0.06 Gastrointestinal: 15.7% (14.4%), NS Female reproductive: 6.5% (5.5%), NS Male reproductive: 0.0% (2.6%), NS Other chronic illness: 7.8% (7.3%), NS *Treatments used* Prescription pharma: 81.7% (73.8%), p=0.03, v=0.05 OTC pharma: 75.9% (66.1%), p=0.01, v=0.06 Herbal medicines: 49.0% (6.2%), p<0.001, v=0.39 Vitamin/mineral supp: 75.2% (45.6%), p<0.001, v=0.16 Homeopathy: 35.3% (4.5%), p<0.001, v=0.32 Flower essences: 39.2% (4.9%), p<0.001, v=0.35 Aromatherapy oils: 43.1% (8.5%), p<0.001, v=0.29 Yoga/tai chi: 43.8% (9.1%), p<0.001, v=0.29 Relaxation/meditation: 52.9% (12.9%), p<0.001, v=0.29

TABLE 2.2: Summary of results on characteristics of users of naturopathy/WHM services

Author (date)	Sample population	Results	
Murthy et al. (2014)	Women (60-65 years) with back pain	9.5% reported consulting with a naturopath for back pain. Women who consulted a naturopath had different consultation rates with the following health professionals (compared to women who did not):	
		Consult with a GP Never: 29% (45%) 1 or 2 times: 29% (24%) More than 3 times: 42% (30%) Orthopaedic surgeon Never: 86% (92%) 1 or 2 times: 8% (6%) More than 3 times: 3% (1%)	*Occupational therapist* Never: 94% (98%) 1 or 2 times: 4% (1%) More than 3 times: 2% (1%) Pharmacist Never: 62% (80%) 1 or 2 times: 12% (9%) More than 3 times: 26% (11%)
Ng et al. (2020)	General population – cancer	*Likelihood of consulting with a naturopath compared with non-cancer population* Overall cancer group (Odds ratio; 95% confidence interval) 2011: 1.42, 1.03-1.95 2014: NS 2011-2015: 1.33, 1.05-1.68	
Peng et al. (2015)	Mid-aged women post-menopause	*Of the post-menopause women with oophorectomy who consulted with a naturopath, this is the proportion who had symptoms (compared to women with no oophorectomy)* Hot flushes: 43% Night sweats: 39% Depression: 41% (26%), p<0.05 Anxiety: 41% (28%), p<0.05 Tiredness: 60% Stiff or painful joints: 74% Back pain: 71% Vaginal discharge: 13% Leaking urine: 49% (32%), *p<0.05*; OR 2.08, 1.20-3.59, *p=0.009* Headaches: 50% Palpitations: 31% *Of the post-menopause women with hysterectomy who consulted with a naturopath, this is the proportion who had symptoms (compared to women with no hysterectomy)* Hot flushes: 39% Night sweats: 30% Depression: 24% Anxiety: 33% Tiredness: 58% (46%), *p<0.05*; OR 1.48, 1.00-2.21, *p=0.05* Stiff or painful joints: 72% Back pain: 64% Vaginal discharge: 9% Leaking urine: 33% (32%), *p<0.05* Headaches: 49% Palpitations: 25%	*Of the post-menopause women with natural menopause who consulted with a naturopath, this is the proportion who had symptoms (compared with women with no natural menopause)* Hot flushes: 32% Night sweats: 26% Depression: 20% Anxiety: 28% (23%), *p<0.05* Tiredness: 44% (38%), *p<0.05* Stiff or painful joints: 61% Back pain: 55% Vaginal discharge: 6% Leaking urine: 23% Headaches: 32% Palpitations: 16%
Sibbritt et al. (2010)	Women (28-36 years)	10% of women with back pain who did not seek help for that back pain, reported consulting with a naturopath/herbalist in the previous 12 months 19% of women with back pain who did seek help for that back pain, reported consulting with a naturopath/herbalist in the previous 12 months 11% of women who did not have back pain, reported consulting with a naturopath/herbalist in the previous 12 months 20% of women with back pain and sought help for back pain in 2003 and 2006, reported consulting with a naturopath/herbalist in the previous 12 months 18% of women with back pain and sought help for back pain in 2006, reported consulting with a naturopath/herbalist in the previous 12 months 14% of women with back pain and sought help for back pain in 2003, reported consulting with a naturopath/herbalist in the previous 12 months 10% of women with back pain and did not seek help for back pain in 2003 or 2006, reported consulting with a naturopath/herbalist in the previous 12 months	

TABLE 2.2: Summary of results on characteristics of users of naturopathy/WHM services

Author (date)	Sample population	Results
Steel et al. (2014a)	Women who identify as pregnant or recently given birth	Private health insurance at time of birth: OR 2.54, 1.52-4.24 Preparing for labour: OR 1.9, 1.31-2.76 *Beliefs* An alternative health practitioner provides more support to me than an obstetrician does: OR 1.56, 1.33-1.71 I find it easier to talk to an alternative health practitioner than a midwife: OR 1.57, 1.26-1.74 An alternative health practitioner spends a longer time with me in consultation when compared with a GP: OR 1.57, 1.24-1.75 Alternative medicine gives me more control over my health/body: OR 1.68, 1.47, 1.80 Alternative medicine is more natural than conventional medicine: OR 1.42, 1.06, 1.64
Steel et al. (2014b)	Women who identify as pregnant or recently given birth	*Likelihood of using the pain management techniques during birth among women who consulted a naturopath for pregnancy-related health conditions* Massage: OR 3.28 (1.80, 5.97) Hypnotherapy: 2.81 (1.16, 6.79) Acupressure/acupuncture: 4.01 (1.33, 12.12)
Bowman et al. (2016)	Women who identify as pregnant or recently given birth	29.3% of women who use herbal medicines for pregnancy-related health conditions also report consulting with a naturopath. This is more than women who report using herbal teas (7.9%) or aromatherapy oils (7.1%) p<0.001
Frawley et al. (2016)	Women who identify as pregnant or recently given birth	Women who consult with a naturopath for pregnancy-related health conditions are more likely (OR 6.51, 3.33-2.72) to have consulted with a naturopath before pregnancy
Steel et al. (2016)	Women who identify as pregnant or recently given birth	Women who report using hypnobirthing for intrapartum pain management also commonly reported consulting with a naturopath for pregnancy-related health conditions (24.0%) compared to women not using hypnobirthing (6.3%) p<0.001
Steel et al. (2012)	Women who identify as pregnant or recently given birth	*The rate of consultation with a naturopath among women during pregnancy were:* Back pain – 1.7% Tiredness – 1.2% Reflux/indigestion – 1.0% Nausea – 1.6% Sciatica – 0.2% Preparing for labour – 0.9% Hip pain – 0.1% Leg cramps – 0.6% Constipation – 0.5% Headache – 0.2% Sleeping problems – 0.7% Neck pain – 0.2% Repeated vomiting – 0.4% Vaginal bleeding – 0.1% Varicose veins – 0.2% Fluid retention – 0.3% Anaemia – 0.3% High blood pressure – 0.0% Cravings – 0.3% Dizziness or fainting – 0.1% Weight management – 0.2% Gestational diabetes – 0.1% Urinary tract infection – 0.0% Pre-eclampsia – 0.2%
Steel et al. (2017)	Young cohort (2006, 2009, 2012) Women identified as attempting to conceive	*Women attempting to conceive who consulted a naturopath* Used herbal medicines – OR 18.2, AOR 9.33, 3.7-23.8 (p<0.001) Used Chinese medicines – OR 10.9, AOR 4.90, 1.47-16.32 (p<0.001) Premenstrual tension – OR 1.5, AOR 4.2, 1.7-10.4 (p=0.03) Previous miscarriage – OR 0.5, AOR 0.2, 0.0-0.2 (p=0.09)

TABLE 2.3: Summary of results regarding motivations and reasons for consulting with a naturopath

Author/s (date)	Sample population	Results
Caughey et al. (2020)	Women, long-term endometrial cancer survivors	Women who consulted with a naturopath reported doing so to reduce their symptoms
Foley et al. (2020a)	Individuals with chronic illness consulting with a naturopath in a community clinic	Reasons for consulting a naturopath: The health care professional is supportive and compassionate (Strongly agree: 100%), I believe this type of health care is safe (93.3%), This type of health care gives me a sense of control about my health (93.1%), To seek treatment for a long-term illness lasting more than one month (92.6%), To improve general wellbeing and prevent future health problems (89.3%), This type of care gives me hope about my future health (89.3%), I was seeking holistic/natural treatments (86.2%), This type of health care suits my personal belief system (86.2%), To enhance the effectiveness of my current medical treatments/medicines (87.0%), To reduce side-effects of my current medical treatments/medicines (70.0%), I was dissatisfied with my conventional medical treatment and wanted to try something different (63.0%), To seek treatment for an acute illness lasting less than one month (33.3%)
Malhotra et al. (2020a)	Individuals with self-reported sleep disorders	Reasons for consultation: Sleep disorder vs no sleep disorder Acute (1.5% vs 1.1%) Long-term condition (7.5% vs 1.7%) To improve well-being (8.3% vs 2.7%)
McIntyre et al. (2019)	General population	Naturopath Acute illness – 18.3% Long-term health condition – 38.9% Improve wellbeing – 55.6% WHM Acute illness – 23.7% Long-term health condition – 31.6% Improve wellbeing – 51.3%

TABLE 2.4: Summary of results regarding consumers' experience of naturopathic care

Author/s (date)	Sample population	Results
Foley and Steel (2017)	Individuals with chronic illness consulting with a naturopath in an academic clinic	*Patient-centred care scale:* I feel seen and heard as a unique individual by my practitioner – Strongly agree/Agree (100%) My practitioner has a full picture of me as a unique individual – Strongly agree/agree (92.7%), Neutral (5.5%), Strongly disagree/disagree (1.8%) My practitioner is really interested in finding and addressing my health problems – Strongly agree/agree (98.2%), Neutral (1.8%), Strongly disagree/disagree (0.0%) The root causes of my problems are identified by my practitioner – Strongly agree/agree (83.6%), Neutral 12.7%), Strongly disagree/disagree (0.0%) The root causes of my problems are being treated by my practitioner – Strongly agree/agree (90.7%), Neutral (5.6%), Strongly disagree/disagree (1.9%) The treatment is individualised for me at each session – Strongly agree/agree (90.9%), Neutral (9.1%), Strongly disagree/disagree (0.0%) My practitioner receives feedback from my body that guides treatment – Strongly agree/agree (76.4%), Neutral (12.7%), Strongly disagree/disagree (1.8%) My practitioners asks me for feedback from my body that guides treatment – Strongly agree/agree (85.5%), Neutral (5.5%), Strongly disagree/disagree (0.0%) I know what to expect during treatment sessions – Strongly agree/agree (92.7%), Neutral (7.3%), Strongly disagree/disagree (0.0%) My practitioner teaches me ways to relieve symptoms myself – Strongly agree/agree (83.6%), Neutral (10.9%), Strongly disagree/disagree (1.8%) CARE Measure *How was your practitioner at...* Making you feel at ease – Very good /excellent (94.6%), Good (3.6%), Poor/fair (1.8%) Letting you tell your 'story' – Very good /excellent (90.9%), Good (7.3%), Poor/fair (0.0%), Does not apply (1.8%) Really listening – Very good /excellent (83.6%), Good (14.6%), Poor/fair (1.8%) Being interested in you as a whole person – Very good /excellent (90.9%), Good (7.3%), Poor/fair (0.0%), Does not apply (1.8%) Fully understanding your concerns – Very good /excellent (90.9%), Good (7.3%), Poor/fair (1.8%) Showing care and compassion – Very good /excellent (94.6%), Good (5.5%), Poor/fair (0.0%) Being positive – Very good /excellent (96.3%), Good (3.7%), Poor/fair (0.0%) Explaining things clearly – Very good /excellent (92.6%), Good (7.4%), Poor/fair (0.0%) Helping you take control – Very good /excellent (89.1%), Good (9.1%), Poor/fair (0.0%), Does not apply (1.8%) Making a plan of action with you – Very good /excellent (83.6%), Good (14.6%), Poor/fair (0.0%), Does not apply (1.8%) Total CARE measure score (mean 46.0, SD 5.7, min 30, max 50) *Perceived provider support scale and empathy scale:* My practitioner cares about me – Strongly agree/agree (100.0) I feel cared for during treatment – Strongly agree/agree (100.0) My practitioner accepts me as I am – Strongly agree/agree (98.2), Neutral (1.8) I receive personal attention during treatment – Strongly agree/agree (100.0) I can talk openly with my practitioner – Strongly agree/agree (98.2), Neutral (1.8) My practitioner gives me hope – Strongly agree/agree (92.7), Neutral (5.5), Does not apply (1.8%) I trust my practitioner – Strongly agree/agree (100.0) *Empowerment scale:* Do you feel more in control of your health? – No (3.6), Yes a little (49.1), Yes a lot (47.3) Do you know what to do to take care of your health problem? – No (0.0), Yes a little (50.9), Yes a lot (49.1) Do you believe that your health problem will improve? – No (0.0), Yes a little (36.4), Yes a lot (63.6) Do you advocate more for yourself? – No (3.9), Yes a little (53.9), Yes a lot (42.3) Do you have techniques you can use when your symptoms get worse? – No (15.1), Yes a little (52.8), Yes a lot (32.1)

TABLE 2.4: Summary of results regarding consumers' experience of naturopathic care

Author/s (date)	Sample population	Results
Foley et al. (2020b)	Patients with chronic illness consulting with a naturopathy in a community clinic	*Patient-centred care scale:* (mean, SD), comparative data for patients also consulting with a GP I feel seen and heard as a unique individual by my practitioner – Naturopath (4.74, 0.45), GP (3.84, 1.03) My practitioner has a full picture of me as an individual – Naturopath (4.29, 0.78), GP (3.72, 1.14) My practitioner is really interested in finding and addressing my health problems – Naturopath (4.61 0.50), GP (3.76, 1.09) The root causes of my problems are identified by my practitioner – Naturopath (4.16, 0.82), GP (3.48, 1.16) The root causes of my problems are being treated by my practitioner – Naturopath (4.19, 0.83), GP (3.60, 1.19) The treatment is individualised for me at each session – Naturopath (4.58, 0.56), GP (3.52, 1.00) My practitioner/doctor receives feedback from my body that guides treatment – Naturopath (4.03, 0.75), GP (3.63, 0.82) My practitioner asks for feedback from my body that guides treatment – Naturopath (4.10, 0.78), GP (3.67, 0.92) I know what to expect during treatment sessions – Naturopath (4.23, 0.62), GP (3.76, 0.93) My practitioner teaches me ways to relieve symptoms myself – Naturopath (4.48, 0.63), GP (3.40, 0.87) *Perceived provide support scale:* My practitioner cares about me – Naturopath (4.66, 0.48), GP (4.16, 0.80) I feel cared for during treatment – Naturopath (4.66, 0.48), GP (4.04, 0.89) My practitioner accepts me as I am – Naturopath (4.59, 0.50), GP (4.08, 0.70) I receive personal attention during treatment – Naturopath (4.66, 0.48), GP (4.12, 0.78) I can talk openly with my practitioner – Naturopath (4.56, 0.56), GP (4.08, 1.00) My practitioner gives me hope – Naturopath (4.38, 0.66), GP (3.58, 1.148) I trust my practitioner – Naturopath (4.72, 0.46), GP (4.04, 0.89) *Empowerment scale:* Do you feel more in control of your health? Naturopath (2.53, 0.57), GP (1.96, 0.68) Do you know what to do to take care of your health problem? Naturopath (2.53, 0.57), GP (2.25, 0.60) Do you believe that your health problem will improve? Naturopath (2.34, 0.70), GP (1.96, 0.79) Do you advocate more for yourself? Naturopath (2.38, 0.71), GP (2.16, 0.69) Do you have techniques you can use when your symptoms get worse? Naturopath (2.42, 0.56), GP (2.00, 0.71) *Patient Assessment of Chronic Illness Care:* Over the past 6 months, when receiving medical care for my chronic condition I was... Asked for ideas when we made a treatment plan – Naturopath (3.97, 1.02), GP (2.88, 1.13) Given choices about treatment to think about – Naturopath (4.39, 0.80), GP (3.50, 0.93) Asked to talk about any problems with my medicines/treatments of their effects – Naturopath (4.57, 0.68), GP (3.38, 1.13) *Domain Total:* Naturopath (4.30, 0.67), GP (3.26, 0.89) Given a written list of things I should do to improve my health – Naturopath (4.63, 0.72), GP (3.08, 1.19) Satisfied that my care was well organised – Naturopath (4.71, 0.46), GP (3.44, 1.19) Shown how what I did to take care of my illness influenced my condition – Naturopath (4.17, 0.79), GP (3.24, 0.93) *Domain Total* – Naturopath (4.50, 0.47), GP (3.25, 0.93) Asked to talk about my goals in caring for my illness – Naturopath (4.20, 1.06), GP (2.80, 1.04) Helped to set specific goals to improve eating or exercise – Naturopath (4.41, 0.82), GP (2.63, 1.10) Given a copy of my treatment plan – Naturopath (4.65, 0.66), GP (2.30, 1.40) Encouraged to go to a specific group or class to help me cope with my chronic illness – Naturopath (3.36, 1.13), GP (2.42, 1.18) Asked questions, either directly or on a survey, about my health habits – Naturopath (4.33, 0.71), GP (3.28, 1.24) *Domain Total:* Naturopath (4.21, 0.58), GP (2.66, 0.95) Sure that my practitioner thought about my values and my traditions when they recommended treatments to me – Naturopath (4.67, 0.66), GP (3.64, 1.11) Helped to make a treatment plan that I could do in my daily life – Naturopath (4.52, 0.77), GP (2.71, 1.20) Helped to plan ahead so I could take care of my illness even in hard times – Naturopath (4.29, 0.81), GP (2.59, 1.05) Asked how my chronic illness affects my life – Naturopath (4.14, 1.11), GP (2.91, 1.31) *Domain Total*: Naturopath (4.42, 0.61), GP (2.93, 0.97) Contacted after a visit to see how things were going – Naturopath (3.11, 01.23), GP (2.08, 1.38) Encouraged to attend programs in the community that could help me – Naturopath (3.15, 1.16), GP (2.17, 1.19) Referred to a dietitian, health educator or counsellor – Naturopath (3.15, 1.32), GP (2.58, 1.38) Told how my visits with other types of practitioners, like doctors or specialists, helped my treatment – Naturopath (3.71, 1.08), GP (2.90, 1.09) Asked how my visits with other doctors/practitioners were going – Naturopath (3.87, 1.06), GP (3.04, 1.27) *Domain Total:* Naturopath (3.34, 0.89), GP (2.59, 1.05) PACIC total Naturopath (4.04, 0.54), GP (2.84, 0.94)
Lucas et al. (2020)	Parents of 0 – 12-year-old children who use CAM and live in Australia	*Used naturopaths as information source: 42.6%*
McIntyre et al. (2019)	General population	*Disclosure of conventional (pharmaceutical) medicines* I told them about all conventional medicines I was using – 50.4% (N), 38.2% (WHM) I only told them about some of my conventional medicine use – 29.8% (N), 36.8% (WHM) I did not tell them about my conventional medicine use – 19.8% (N), 25.0% (WHM)

APPENDIX 3.1: Search terms for bibliometric analysis of adverse effects of herbs and supplements from MEDLINE (via Ovid) (search conducted on 28 October 2022)

MEDLINE search terms

toxicity

adverse reaction

side-effect

adverse event

adverse effect

herbal

plants, medicinal (MeSH term subheading of adverse effects)

herbal medicine (MeSH term subheading of drug effects)

plant, preparations (MeSH term, subheading of adverse effects)

plant, extracts (MeSH term, subheading of adverse effects)

phytotherapy (MeSH term, subheading of adverse effects)

homeopathy (MeSH term)

vitamins (MeSH term, subheadings of adverse effects, poisoning, toxicity)

minerals (MeSH term, subheadings of adverse effects, poisoning, toxicity)

calcium, dietary (MeSH term, subheadings of adverse effects, poisoning, toxicity)

dietary, supplements (MeSH term, subheadings of adverse effects, poisoning, toxicity)

iron, dietary (MeSH term, subheadings of adverse effects, poisoning, toxicity)

potassium, dietary (MeSH term, subheadings of adverse effects, poisoning, toxicity)

antioxidants (MeSH term, subheadings of adverse effects, poisoning, toxicity)

flavonoids (MeSH term, subheadings of adverse effects, poisoning, toxicity)

trace, elements (MeSH term, subheadings of adverse effects, poisoning, toxicity)

sodium, dietary (MeSH term, subheadings of adverse effects, contraindications, toxicity)

phosphorus, dietary (MeSH term, subheadings of adverse effects, toxicity)

dietary, fibre (MeSH term, subheadings of adverse effects, toxicity)

APPENDIX 3.2: Letter from the National Institute of Complementary Medicine (NICM) to Health Minister regarding the review of private health insurance rebates for natural therapies

NICM

The science of integrative medicine

The Honourable Greg Hunt, MP
Minister for Health
Parliament House
Canberra ACT 2600
Emailed to: Minister.Hunt@health.gov.au

Dear Minister,

Review of the Australian Government Rebate on Natural Therapies for Private Health Insurance

As the Director of the NICM health research institute at Western Sydney University I applaud the Government on the recently announced reforms to make private health insurance simpler and more affordable. The package of reforms was based in part on the work of the *Review of the Australian Government Rebate on Private Health Insurance for Natural Therapies* (chaired by Dr Chris Baggoley) (the Review) which was charged with reviewing evidence in support of 17 key natural therapy interventions. I was invited to participate in and contribute to the discussions of the Review group at various stages.

The Review recommended the Government rebate for the following natural therapies be removed from private health insurance products on the basis that there was no clear evidence demonstrating efficacy: alexander technique, aromatherapy, bowen therapy, buteyko, feldenkrais, herbalism, homeopathy, iridology, kinesiology, naturopathy, pilates, reflexology, rolfing, shiatsu, tai chi, and yoga. **NICM strongly recommends the continued inclusion of the following natural therapies for Government health insurance rebates: herbal medicine, naturopathy, tai chi, yoga.**

NICM is concerned that the proposed reforms are in some cases *not* based on sound scientific evidence and likely to result in cost shifting to the public purse with the removal of the rebate on those natural therapies that show good evidence of efficacy and effectiveness in disease prevention. The removal of this rebate will also likely act as a disincentive to young people in particular in maintaining private health insurance.

Complementary medicines and therapies (CM) play a significant role in the health of our community and integrating the use of well-evidenced CM in the healthcare of all Australians is increasingly part of routine clinical practice. Australian consumers understand that CM is not a replacement of prescription medicines, but rather used to enhance overall wellbeing and for maintenance of health and, as healthcare costs spiral, there is an imperative to move towards a more preventive model of healthcare.

The Review overlooked scientific evidence of efficacy and effectiveness in relation to four key therapies: herbalism, naturopathy, yoga and tai chi

There is solid evidence of efficacy and effectiveness of four key therapies that the Review missed.

Herbalism and naturopathy
The Review acknowledged the short time-frame available to examine the very significant volume of evidence in these two complex areas, however unfortunately in response adopted a literature search process that was unable to generate relevant evidence. Quite simply the search terms were not commonly used mesh terms that sought evidence of 'whole practice' rather than examining the treatments employed by naturopaths or herbalists. This resulted in minimal findings that were not representative of the best available evidence in these fields. Effectively, by adopting these inappropriate search terms considerable scientific evidence related to the key tools of trade of the naturopathy and herbal medicine professions were excluded from consideration by the Review.

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WESTERN SYDNEY UNIVERSITY

There are well-established, alternative, time efficient approaches to searching the scientific literature that have been utilised in other Australian government reviews. For example, a recent evaluation of the scientific evidence in these fields had been undertaken by the Victorian Department of Human Services.[1] The Victorian Department of Human Services review of the practice and regulatory requirements of naturopathy and western herbal medicine published in 2005 determined that, in the absence of whole practice research, the best way to evaluate health disciplines effectively and objectively was to focus on their major therapeutic tools. The Victorian Government report concluded substantial benefits for the effectiveness of a number of nutritional supplements and herbal medicines as key tools of trade of naturopathy and western herbal medicine. The Australian Therapeutics Goods Administration also provides clear Government guidelines on how to undertake these reviews of scientific evidence.[2] These Government documents sit in sharp contrast to the current Review.

Provision of dietary supplements is one of the key tools of trade of both naturopaths and western herbal medicine practitioners. Studies here and overseas have shown that most people in the West are not consuming a diet that is sufficiently high in quality nutrients. A striking example is the detection of scurvy in a number of patients at Sydney's Westmead hospital in 2016.[3] While good advice on a healthy diet is the appropriate response in the first instance, there is evidence that supplements may be required and clinically necessary in some instances. A 2016 meta-analysis found that vitamin D supplementation could have a role in the management of chronic pain (and may contribute beneficially to the current overuse of opioid medications).[4] Further, vitamin D supplementation has been found to be safe and protective against acute respiratory tract infection with the protective effect greater in individuals who are very vitamin D deficient.[5] It is also well accepted that the risk of medical events associated with some conditions can be reduced by provision of supplements, including for example, folic acid/B6/B12.[6] Scientific evidence is widely available that supports the use of these treatments but the approach used by the Review, unlike other Government reports, failed to capture this critically important evidence. These extraordinary omissions seem inconsistent with the Review's aim to 'examine the evidence of clinical efficacy, cost effectiveness, safety and quality of natural therapies.'

Exercise therapies including yoga and tai chi

The benefit of exercise therapies to overall health and well-being is no longer in doubt. The Mayo Clinic, one of the pre-eminent medical clinics in the world, notes the following on their website: *"Want to feel better, have more energy and even add years to your life? Just exercise. The health benefits of regular exercise and physical activity are hard to ignore. Everyone benefits from exercise, regardless of age, sex or physical ability."* Exercise controls weight, combats health conditions and diseases, improves mood, boosts energy, promotes better sleep, puts the spark back into your sex life, can be fun … and social.[7] Yoga and tai chi fall squarely under the broad umbrella of exercise therapies and there is significant evidence of the efficacy and effectiveness of both therapies relevant to disease prevention.

A substantial body of scientific literature exists on the effectiveness of yoga for various medical conditions: almost 500 research publications meeting the criteria for a clinical trial have been published between 1967 and 2013[8] leading to numerous systematic reviews and meta-analyses of these clinical trials. There is growing evidence for the effectiveness of yoga as an intervention for depression, anxiety and PTSD.[9,10,11,12,13,14,15,16] With the increasing rates of depression and anxiety in the Australian population it is vital such a therapy remains a management option for this group through private health insurance. A meta-analysis published in 2014[17] reported that relative to usual care or no intervention, yoga improved numerous factors associated with cardiovascular disease, including improved systolic and diastolic blood pressure, heart rate, respiratory rate, waist circumference, waist/hip ratio, total cholesterol, HDL, VLDL, triglycerides, HbA1c, and insulin resistance. The meta-analysis revealed evidence for clinically important effects of yoga on most biological cardiovascular disease risk factors and that yoga can be considered as an ancillary intervention for the general population and for patients with increased risk of cardiovascular disease.

The safety and health benefits of tai chi mind-body exercise have been documented in a large number of clinical studies focused on specific diseases and health conditions. By way of example, there is considerable evidence of the effectiveness tai chi in preventing falls, with randomised controlled clinical trials consistently demonstrating that tai chi is effective in reducing the risk of falls in the elderly. A meta-analysis published in 2017 assessing the effectiveness of tai chi for falls prevention in the older adult population and at-risk adults (compared to usual care or other falls prevention interventions) found practising tai chi reduced falls by 43% in those followed over one year or less, and continued to reduce falls in those followed for longer periods.[18]

Researchers from the Institute for Aging Research of Harvard Medical School working for a number of years with residents at a Boston-based senior health care organisation have shown that regular practice of tai chi reduces the risk of falls among older adults and benefits both balance and mobility – it aids the muscular system, coordination, equilibrium, and the brain.[19] Given Australia has an ageing population and the risk of falling and fall injury increases with age, and more than one in three community dwelling people aged 65 years and over experience a fall annually, it is vitally important the community has ready access to exercise therapies that can mitigate the risk of falls and falls injury. This is doubly important as the rates of hospitalisation are high for falls, as are the acute care costs associated with these falls.[20,21,22,23] Removing this Government rebate neither makes economic sense nor is it based on sounds scientific evidence.

Evidence based integrative healthcare fills an important void in the Australian health care landscape by bolstering preventive healthcare approaches

Over 70% of Australian adults use over-the-counter CM products and approximately one-third use CM therapies such as massage therapy, naturopathy and chiropractic each year. One of the main reasons people choose CM is to manage chronic disease, improve wellbeing and as a preventative healthcare approach.[24,25,26,27] Many consumers with chronic disease look outside conventional medical care for other approaches to ease their symptoms associated with chronic disease and delay the disease course or disease exacerbation. Consumers seek to participate and collaborate in treatment decisions, they value choice and are positively drawn to integrative healthcare practices for preventive and adjunctive therapy. As health care costs continue to spiral it is imperative that the Australian community is supported in their healthcare choices. The complementary medicine sector is an important contributor to the Australian economy with annual industry revenue reaching $4 billion in 2017 and growing at 3.1%pa.[28,29]

NICM health research institute strongly recommends the continued inclusion of the following natural therapies for Government health insurance rebates: herbal medicine, naturopathy, tai chi, yoga. We would be pleased to offer ongoing support and discussion around the scientific evidence on this matter.

Sincerely

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Director

9 February 2018

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APPENDIX 3.3: High-risk activities that form part of the usual scope of practice of naturopaths and herbalists

High-risk activity No. 1: Putting an instrument, hand or finger into a body cavity

Qualified naturopaths and herbalists are trained to use otoscopes and tongue depressors in the physical examination of patients and to use thermometers in assessing patient vital signs. Otoscopes may be placed into the external ear canal up to the tympanic membrane or into the nasal passage, beyond the point where they normally narrow. Tongue depressors may be placed towards the back of the tongue. Thermometers may be placed either in the mouth or the external ear canal (Doolan 2024).

High-risk activity No. 4: Procedures below the dermis, mucous membrane, in or below surface of cornea or teeth

Naturopaths often employ diagnostic tests that require drawing blood from the patient using sub-dermal lancets (i.e. 'skin pricks'). These are commonly undertaken on-site during the clinical encounter. They require the naturopath to have a sound and up-to-date understanding of infection prevention and control procedures to minimise the risk of spreading infectious diseases (ANC 2022: 29).

High-risk activity No. 5: Prescribing a scheduled drug, supplying a scheduled drug (includes compounding), supervising that part of a pharmacy that dispenses scheduled drugs

Naturopaths and herbalists routinely prescribe orally administered herbs and nutrients (Casey et al., 2007; Wardle et al., 2019). However, under Australian drugs and poisons laws, naturopaths are not currently authorised to prescribe scheduled medicines that are in herbal form, even though these appear in pharmacopoeias around the world and are part of the usual scope of practice of naturopaths in other countries. There are a wide range of products that are considered the 'tools of the trade' of qualified naturopaths. Most are extemporaneously dispensed[123] for an individual patient, that is, they are prescribed for an individual patient and compounded on-site at the naturopathic clinic. For example, herbal tinctures or powdered products are mixed into a unique formula to address the health needs of an individual patient. Extemporaneous dispensing requires practitioners to have professional training in extemporaneous compounding, to have knowledge and skills regarding issues of quality, identification, substitution, and contamination of raw materials, dilutions and dosages of compounded CM and hygienic manufacture of CM (Doolan 2024).

Also, many products prescribed by naturopaths are classed as 'practitioner only products',[124] that is, products that are listed or registered on the Australian Register of Therapeutic Goods. Labelling and supplying products as 'practitioner only' allows the product company to make stronger claims of health effects than those products supplied solely for retail purchase. Naturopaths supplying practitioner only products to patients can apply to certain professional associations that have been approved by the Australian Government Department of Health and Aged Care's TGA for a TGA *Advertising Certification of Exemption*. This certificate is recognised by herbal medicine wholesalers and enables the naturopath to purchase practitioner only products with the expectation that they are appropriately qualified to make sense of the material and draw on their more advanced training to determine safe and appropriate use of the product.

High-risk activity No. 6: Administering a substance by injection

Some naturopaths and herbalists who are trained in biomesotherapy inject saline or other substances into patients. Single-use, sterile diabetic syringes are used to insert a sterile saline solution just under the skin or into specific points. Treatment into and around joints is also common. These activities require practitioners to have a sound understanding of infection prevention and control procedures (Doolan 2024).

High-risk activity No. 7: Supplying substances for ingestion

Naturopaths and herbalists are trained to prescribe and supply therapeutic substances for ingestion by their patients. Naturopaths typically operate a dispensary from their clinic, supplying herbal medicines and nutritional medicines to patients. Between 69% and 79% of naturopaths report often prescribing liquid herbal medicines (usually aqueous ethanolic extracts), nutritional supplements and/or herbal tablets in clinical practice (Steel et al., 2020). Researchers report that over 97% of naturopaths and herbalists operate a dispensary and over 96% of these practitioners compound individual and multi-herbal formulae for patients (Casey et al., 2007).

High-risk activity No. 8: Pre-conception care, managing labour, delivering or assisting with the delivery of a baby

While management of labour is not a common part of

123 Extemporaneous (not prepared) herbal or nutritional supplements are exempt from Part 3-3 of the Therapeutic Goods Act 1990 (Cth) requiring manufacture of CM under Good Manufacturing Practice (GMP). This means the preparation is for use in the course of business and:
(a) the preparations are manufactured on premises that the person …occupies and … is able to be closed … to exclude the public; and
(b) the person carrying on the business:
(i) supplies the preparation … to a particular person after consulting with that person and
(ii) uses their own judgement as to the treatment required (*Therapeutic Goods Regulations* 1990 (Cth) Sch 8 s (4).

124 Naturopathic and WHM practitioners may dispense 'for practitioner dispensing only' labelled products (*Therapeutic Goods Order No 92 Standard for Labels of Non-Prescription Medicines*), s 8 (1)(n)(A). Unlike other listed or registered CM products, practitioner only products do not have their purpose or therapeutic indication on the label (TGO No 92), s 8 (1)(n)(B) and rely on the practitioner to know their purpose or therapeutic indication. Such medicines should only be sold to a practitioner for supply to a person after the practitioner affixes an instruction label on the medicine following a consultation with the person (TGA, 2018: 17). Similarly, naturopaths who are members of certain professional associations (*Therapeutic Goods Act 1989* (Cth) s 42AA) may receive advertising directly and exclusively from sponsors that exempt the sponsors from complying with usual advertising requirements (TGA, 2018: 17). Practitioners are assumed to have the knowledge and skills to critically analyse advertisements and recognise their persuasive intent (TGA, https://www.tga.gov.au/resources/resource/guidance/advertising-health-professionals). Practitioner only products do not exist as a category under the *Therapeutic Goods Act 1989* (Commonwealth Government Expert Committee on Complementary Medicines in the Health System, 2003).

scope of practice of naturopaths and herbalists, one study showed that 7% of pregnant women consulted naturopaths (Steel et al., 2012: 3). Women seek advice for pre-conception care, during pregnancy and to induce labour. There is also evidence that Australian pregnant women who report preparing for labour are twice as likely to consult a naturopath compared to women who do not prepare for labour. Towards the end of pregnancy, naturopaths may prescribe treatments to facilitate labour and childbirth and with the aim of modulating the frequency of uterine contractions and preventing medical interventions (Steel & Martin 2019: 722).

High-risk activity No. 11: Primary care practitioners who see patients with or without a referral from a registered practitioner

Naturopaths and herbalists provide primary care consultations with or without a referral from a medical practitioner or other registered health practitioner. They provide naturopathic care to around 6-8% of the Australian population (McIntyre et al., 2019; Steel et al., 2018), representing around four million consultations each year (McIntyre et al., 2019). An estimated 2 million Australians see a naturopath at least annually, of whom 60% consider their naturopath to be their primary health provider, and 22% consult a naturopath as their sole health care provider (Wardle et al., 2019).

The rate of use of naturopathic and herbalist services in the Australian community appears to have remained relatively stable for the past 25 years (MacLennan et al., 2002; MacLennan et al., 2006; Steel et al., 2018). These findings confirm the enduring presence of naturopathy and naturopaths in the Australian healthcare system as primary care clinicians.

High-risk activity No. 12: Treatment commonly occurs without others present

Naturopaths and herbalists operate principally from a private practice; most practise autonomously and often with no one else present in the clinic. A survey of practitioners found that 72.5% of 280 naturopaths reportedly worked in solo clinical practice (Steel et al., 2020). For practitioners who reported sharing a clinic location with other health practitioners, the vast majority still conduct private consultations with patients rather than as part of a team with supervision to guide, support, or monitor their practice (Department of Health 2009: 20).

High-risk activity No. 13: Patients commonly required to disrobe

Naturopathy is an eclectic therapeutic practice that incorporates many different treatment modalities. Some naturopaths include manual therapies such as massage, dry needling, Bowen Therapy, myotherapy, Tui Na and moxibustion in their range of offerings. When receiving such treatments, patients are required to disrobe to enable physical examination and the application of manual therapy techniques.

APPENDIX 3.4: Selected scheduled (restricted) herbs that naturopaths in Australia are unable to use due to medicines scheduling arrangements

Aconitum spp (Aconite, Monkshood, Wolfsbane)
Acorus calamus (Sweet flag or Sweet sedge)
Aristolochia spp (Chinese fairy vine)
Atropa belladonna (Deadly nightshade)
Borago officinalis (Borage)
Colchicum autumnale (Autumn crocus or Meadow saffron)
Convallaria spp (Lily of the valley)
Datura spp (Jimsonweed or Thornapple)
Digitalis (Foxglove)
Ephedra spp (Ma huang)
Gelsemium spp (Yellow jasmine)
Hyoscyamus niger (Henbane)
Piper methysticum (Kava)
Lobelia inflata (Indian tobacco)
Mandragora officinalis (Mandrake)
Melilotus officinalis (Sweet clover)
Pulmonaria spp (includes Lungwort)
Rauwolfia spp (Indian snake root)
Sanguinaria canadensis (Bloodroot)[125]
Senecio spp
Symphytum spp (Comfrey)
Tanacetum vulgare (Tansy)
Tussilago farfara (Coltsfoot)

Source: Lin et al., 2005: 109.

125 Effective 1 Feb 2020. Sch 10 Bloodroot.

APPENDIX 6.1: Naturopathy and WHM education providers located in 2003 and 2021

Education institution found in 2003	Education institution found in 2021
Academy of SAFE Therapies (Gold Coast campus) (QLD)	
Adelaide Training College of Complementary Medicine (SA)	
Athene College of Traditional Medicine, (WA)	
Australasian College of Natural Therapies (NSW)	Now operating as Torrens University Australia
Australasian College of Nutritional and Environmental Medicine (VIC)	
Australian Centre for Complementary	
Medicine Education and Research (QLD)	
Australian College of Herbal Medicine (VIC)	
Australian College of Natural Medicine (Brisbane Campus) (QLD)	Now operating as Australian College of Natural Medicine, trading as Endeavour College of Natural Health
Australian College of Natural Medicine (Gold Coast Campus) (QLD)	Now operating as Australian College of Natural Medicine trading as Endeavour College of Natural Health
Australian College of Natural Medicine (Perth Campus) (WA)	Now operating as Australian College of Natural Medicine trading as Endeavour College of Natural Health
Australian College of Natural Medicine Inc. (VIC)	Now operating as Australian College of Natural Medicine trading as Endeavour College of Natural Health
Australian Institute of Applied Sciences (QLD) (formerly National Institute of Health Sciences)	
Australian Institute of Holistic Medicine (WA)	
Canberra Institute of Technology (ACT)	
Central TAFE (WA)	
Charles Sturt University (NSW)	
College of Somatic Studies (QLD)	
Dorothy Hall College of Herbal Medicine (NSW)	
Dunn's Private College of Herbalism and Naturopathy (WA)	
	Endeavour College of Natural Health (campuses in Adelaide SA, Brisbane and Gold Coast Qld, Melbourne Vic, Perth WA, Sydney NSW). Endeavour College of Natural Health is the trading name for the Australian College of Natural Medicine (see above).
Gold Coast Institute of TAFE (QLD)	
Gracegrove College (NSW)	
Health Schools Australia (QLD)	
Institute of TAFE (TAS)	
Island Health College (TAS)	
The Kinesiology Academy (QLD)	
La Trobe University (VIC)	
Laws College of Naturopathy (VIC)	
Melbourne College of Natural Medicine (Box Hill Campus) (VIC)	Now operating as Australian College of Natural Medicine trading as Endeavour College of Natural Health
Melbourne College of Natural Medicine (Melbourne Campus) (VIC)	Now operating as Australian College of Natural Medicine trading as Endeavour College of Natural Health
National College of Traditional Medicine (VIC)	
Nature Care College (NSW)	Nature Care College (NSW)

Education institution found in 2003	Education institution found in 2021
NSW School of Natural Medicine (NSW)	
Paramount College of Natural Medicine (WA)	
Perth Academy of Natural Therapies (WA)	
Robynn Morro's College of Natural Medicine (QLD)	
SA College of Natural and Traditional Medicines (SA)	
SA Health Education Centre (SA)	
Southern Cross Herbal School (QINS) (NSW)	
Southern Cross University (NSW)	Southern Cross University (NSW). The University terminated its naturopathy degree in 2017. It subsequently relaunched its naturopathy program in 2020.
Southern School of Natural Therapies (VIC)	Now operating as Torrens University Australia
Swinburne University (VIC)	
	Switch on Health
	Torrens University Australia. TUA acquired Australasian College of Natural Therapies (NSW) and Southern School of Natural Therapies.
University of Newcastle Research Associates (NSW)	
University of New England (NSW)	
University of South Australia (SA)	
University of Sydney (NSW)	
University of Western Sydney (NSW)	
Victoria University of Technology (VIC)	

APPENDIX 6.2 Resources used in Bachelor of Health Science degree to educate naturopathy students on safe prescribing and practice.

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Interactions

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Herb Drug Databases

- Clinical Key for Nursing
- eMims
- Department of Health Therapeutic Goods Administration. (n.d). Prescribing medicines in pregnancy database. Retrieved from https://www.tga.gov.au/prescribing-medicines-pregnancy-database
- IM Gateway
- Natural Medicine Database
- Npod

Websites

- American Botanical Council
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- www.tga.gov.au/reporting-adverse-events
- Code of Conduct Unregistered Health Professionals. www.health.nsw.gov.au/phact/Documents/coc-unregistered-practitioners.pdf
- Code of Conduct – various Professional Bodies
- Health Care Complaints Commission
- TGA Database of Adverse Event Notifications (DAEN)
- TGA Pregnancy & Lactation classifications re safety
- TGA Safety Alerts
- Therapeutic Goods Administration (2018). Australian regulatory guidelines for complementary medicines (ARGCM) (version 7.2)
- Substance Checker on the ASADA website www.asada.gov.au/substances

Tools

- Custom Herbal Monographs showing herb/drug interactions, contra-indications and cautions & safety in pregnancy and lactation
- Drug Monograph Template
- Work Integrated Learning Student Handbook
- Clinical Practicum Handbook
- Clinic Supervisor Manual and Resources
- AIMA guidelines for interprofessional communication.
- Herb/Drug Pregnancy and Lactation Categorisation System
- Client Adverse Event form
- Adverse events procedure
- National Adverse Events Spreadsheet

Industry Expert Podcasts focused on Integrated Pharmacology

- Maxwell Hacker; (Naturopath & Registered Nurse): Scope of Practice and Safe Practice in Integrated Environment
- Sarah Gray; (Pharmacist & Nutritionist): Interactions
- Teresa Mitchell-Paterson; (Naturopath & Nutritionist): Oncology Care.
- Dr Greg Connolly; (Naturopath): Oncology Care.
- Panel Discussion: Integrative Care.
  - Alison Kane (Naturopath & Nutritionist), Simone Morley (Pharmacist and Herbalist), Andrea Williams (Myotherapy), Dr Amber Moore (Chinese Medicine), Sara Gray (Pharmacist & Nutritionist).
- FX Medicine (2019, Jan 9th). Polypharmacy: The role of the integrative pharmacist with Jacqui Hagidimitriou [audio file]. Retrieved from www.fxmedicine.com.au/content/polypharmacy-role-integrative-pharmacist-jacqui-hagidimitriou

Assessment Tools for Prescribing Safety

- Work Health & Safety Quiz: 100% pass required for entry to clinical practice
- Decision Tree Tool
- Decision Wheel Tool
- Supervisor Case Assessment Tool
- Reflective Practice Template
- Objective Structured Clinical Examination (OSCE) – exit examination of physical examination skill, clinical reasoning, safety, ethics and oral communication skill.

APPENDIX 7.1: List of naturopathy professional associations/organisations – 2005 and 2021-22

2004 List of associations	Surveyed 2005	Within scope 2021	Comments
Alumni Association of Natural Medicine Practitioners (AANMP)	Yes	No	Not found in 2021
Australian Association of Homotoxicology (AAH)	Yes	No	Not found in 2021
Australian College of Herbal Medicine (ACHM)	No	No	Not found in 2021
Australian College of Nutritional and Environmental Medicine (ACNEM)	Yes	No	Now Australasian College of Nutritional and Environmental Medicine – it is a college not an association
Australian Committee of Natural Therapies (ACONT)	Yes	No	Not found in 2021
Australian Complementary Health Association (ACHA)	Yes	No	Not found in 2021
Australasian Federation of Natural Therapists (AFNT)	Yes	No	Not found in 2021
Australasian Integrative Medicine Association (AIMA)	Yes	No	Lists complementary health practitioners as a membership category but does not mention naturopaths specifically and primarily represents integrative doctors
Australian Naturopathic Practitioners Association (ANPA)	Yes	Yes	Invited. Did not participate in 2021 survey
Australian Natural Therapists Association (ANTA)	Yes	Yes	Invited. Did not participate in 2021 survey
Australian Traditional-Medicine Society (ATMS)	Yes	Yes	Invited. Did not participate in 2021 survey
Complementary Medicine Association (CMA)	Yes	Yes	Participated in 2021 survey
Federation of Natural and Traditional Therapists (FNTT)	Yes	No	Not found in 2021
Naturopaths & Herbalists Association of Australia (NHAA)	Yes	Yes	Participated. Note change of trading name from National Herbalists Association Australia (NHAA)
Naturopathic Practitioners Association (NPA)	No	No	Not found in 2021
Naturopathic Physicians Association of Australia (NPAA)	No	No	Not found in 2021
Society of Natural Therapists and Researchers (SNTR)	Yes	No	Does not mention naturopaths in rules/on website
Australian Register of Naturopaths and Herbalists (ARONAH)	No	Yes	Established 2009. Participated in 2021 survey

APPENDIX 7.2: Comparison of the aims/mission of professional associations that represent or regulate naturopaths in Australia

Name	Aims/mission/objects
Australian Natural Therapists Association (ANTA)	Constitution not publicly accessible on website
Australian Naturopathic Practitioners Association Inc. (ANPA)	Constitution not publicly accessible on website
Australian Register of Naturopaths and Herbalists (ARONAH)	The objects for which the Company is established are:- (1) to register suitably qualified and competent persons in the Profession by admitting such persons as Members and, if necessary, to impose conditions on the admission of such persons in the Profession as Members; (2) to register suitable students and competent persons in the Profession by admitting such persons as Members and, if necessary, to impose conditions on the admission of such persons in the Profession as Members; (3) to decide the requirements for registration or endorsement of registration in the Profession, including the arrangements for supervised practice in the Profession; (4) to develop or approve standards, codes and guidelines for the Profession, including: – (a) the approval of accreditation standards developed and submitted to it by an Accreditation Authority; (b) the development of registration standards; and (c) the development and approval of codes and guidelines that provide guidance to Practitioners registered in the Profession; (5) to approve accredited programs of study as providing qualifications for registration or endorsement in the Profession; (6) to oversee the assessment of the knowledge and clinical skills of overseas-trained applicants for registration in the Profession whose qualifications are not approved qualifications for the Profession, and to determine the suitability of the applicants for registration in Australia; (7) to oversee the receipt, assessment and investigation of notifications about persons who:- (a) are or were Practitioners; or (b) are or were Students; (8) to establish panels to conduct hearings about: – (a) health and performance and professional standards matters in relation to persons who are or were Practitioners; and (b) health matters in relation to Students; (9) to refer matters about Practitioners who are or were registered to responsible tribunals for participating jurisdictions; (10) to oversee the management of Practitioners and Students, including monitoring conditions, undertaking and suspensions imposed on the registration of the Practitioners or Students; (11) to make recommendations to the Ministerial Council about the operation of specialist recognition in the Profession and the approval of specialties for the Profession; (12) to keep up-to-date and publicly accessible national registers of registered Practitioners for the Profession; (13) to keep an up-to-date national register of students for the Profession; (14) at the Company's discretion, to provide financial or other support for health programs for registered Practitioners and students; (15) to give advice to the Ministerial Council on issues relating to the national registration and accreditation scheme for the Profession; (16) if asked by the Ministerial Council, to give to the Ministerial Council the assistance or information reasonably required by the Ministerial Council in connection with the national registration and accreditation scheme; (17) to do anything else necessary or convenient for the effective and efficient operation of the national registration and accreditation scheme; (18) any other function given to the Company by or under the HPRNL Act.
Australian Traditional – Medicine Society (ATMS)	The Society has the following objects: (a) to promote and advance the profession of Natural Medicine; (b) to encourage a high standard of knowledge, ethics and proficiency in the profession of Natural Medicine through life-long learning and accreditation initiatives; (c) to foster and disseminate research in Natural Medicine; (d) to advocate the profession of Natural Medicine to regulators and stakeholders; and (e) to collaborate with stakeholders towards a national occupational regulatory system for the profession of Natural Medicine.
Complementary Medicine Association (CMA)	The objects of the Association are: (a) To promote, encourage, providing internship and counsel in matters relating to complementary medicine and its associated therapies and modalities at the highest level of professional responsibility. (b) To establish and maintain relations with institutions, organisations, colleges and others throughout the world having the same or similar objects. (c) To promote and protect the mutual interest of its Members. (d) To formulate and promulgate a code of ethics applicable to Members. (e) To promote and facilitate the collection, analysis, understanding, circulation and discussion of any information relating to the purpose of the Association and for such purpose to promote, support and send any person or persons as delegates to any place, convention or similar assembly within Australia or overseas. (f) To arrange the exchange of information covering the activities and objects of the Association or any matters to which its objects relate with any other institutions, organisations, college or entity with which the Association is authorised to associate or cooperate.
Naturopaths and Herbalists Association Australia (NHAA)	Enable practitioners and the practice of herbal and naturopathic medicine to become fully integrated into the primary healthcare system in Australia Make herbal and naturopathic medicine accessible to all Maintain the integrity of the profession Continue to promote the standards and quality of education, of the profession Make greater career opportunities and research pathways for herbalists and naturopaths Continue the integration of traditional medicine and evolving science.

APPENDIX 7.3: Schedule 1 of the federal Therapeutic Goods Regulations 1990 (Cth)

Schedule 1—Part 2 does not apply to members of an Australian branch of one of these bodies (subregulation 4(2))

Column 1 Item No.	Column 2 Body
1	Acupuncture Association of Australia
2	Acupuncture Ethics and Standards Organisation
2A	Association of Natural Health Practitioners Limited
3A	Aust China Acupuncture and Chinese Medicine Association Inc.
3B	Australasian Federation of Natural Therapists Inc.
4	Australian Acupuncture Association Ltd.
5	Australasian Association of Ayurveda Incorporated
5A	Australian Association of Exercise and Sports Scientists
6	Australian Association of Professional Homoeopaths
6A	Australian College of Acupuncturists Ltd
7	Australian Committee of Natural Therapies Inc. (SA)
9	Australian Federation of Homoeopaths
9A	Australian Federation of Homoeopaths (Qld.) Inc.
9B	Australian Federation of Homoeopaths (WA) Inc.
10	Australian Natural Therapists Association Ltd
11	Australian Naturopathic Practitioners and Chiropractors Association
11A	Australian Society of Homeopaths Inc
12	Australian Traditional Chinese Herbalists Association (Qld)
13	Australian Traditional Chinese Medicine Association Inc.
14	Australian Traditional Medicine Society
14A	Australian Unani Medicines Society Inc.
15	Chinese Medicine Association Pty Ltd
15A	Chinese Medicine Association of Australia Inc.
16	Complementary Medicine Association
16A	Federation of Chinese Medicine and Acupuncture Societies of Australia
17	Homoeopathic Education and Research Association
17A	International Association of Trichologists
17B	International Christian Association of Natural Therapists Ltd (ICANT)
18	National Herbalists Association of Australia
18A	Naturopathic Physicians Association of Australia Inc.
19	Queensland Naturopathic Association
20	Register of Acupuncture and Traditional Chinese Medicine
21	Society of Natural Therapists and Researchers [SNTR] Inc.
22	Society of Classical Homoeopathy Ltd
23	Traditional Medicine of China Society Australia
24	Society of Chinese Medicine and Acupuncture (Vic) Inc.
25	Naturopathic Practitioners Association Inc.
26	The Acupuncture Association of Australia, New Zealand and Asia
26A	The Alumni Association of Natural Medicine Practitioners Inc.
26AA	Australian Society for Bioregulatory Medicine Incorporated
26B	The Australian Podiatry Association (NSW)
26BA	The Homeopathic Medicine Association Inc.
27	The New South Wales Research Association of Traditional Chinese Medicine

APPENDIX 8.1 Workers' compensation arrangements by state and territory

State/territory Legislation	Regulator	Eligible providers	Status of naturopaths
Workers Compensation Act 1951, No. 2 (ACT)	WorkSafe ACT	Must be recommended by doctor in personal injury plan and agreed by insurer.	Nothing found on website about approved allied health providers or naturopaths.
Workplace Injury Management and Workers Compensation Act 1998 (NSW)	NSW icare State Insurance Regulatory Authority (SIRA)	Treating allied health practitioner disciplines require approval by SIRA in order to be deemed appropriately qualified to provide specified treatment or services in the workers compensation system. Includes chiropractors, osteopaths, and exercise physiologists.	Naturopaths are not included as treating allied health practitioner discipline. There is provision for compensation payments for complementary and alternative therapies for work-*related dust diseases*, on referral from treating medical practitioner.
Return to Work Act 1986 (NT)	NT WorkSafe	If liability for a claim has been accepted, all reasonable medical and rehabilitation services are paid for by the insurer through the workers compensation scheme. No guidelines available about what are reasonable medical and rehabilitation services.	No evidence to suggest naturopaths are included. However, no guidance on website about what are 'reasonable medical and rehabilitation services' and whether the services of naturopaths may be reimbursed.
Workers' Compensation and Rehabilitation Act 2003 (QLD)	WorkCover Queensland	Costs covered for approved registered providers and approved non-board registered providers. In-cludes chiropractors, osteopaths, and acupuncture provided by registered Chinese medicine practi-tioners.	Website lists 'Services we don't cover' and this includes natural therapists and naturopaths.
Workers Rehabilitation and Compensation Act 1986 (SA)	ReturntoWorkSA	Pays for reasonable and necessary health and return to work services. The website lists a range of regis-tered and unregistered health services including chiropractic, osteopathy, and remedial massage, subject to an 'allied health management plan'.	No reference to naturopaths in list of service providers.
Workers Rehabilitation and Compensation Act 1988 (TAS)	WorkSafe Tasmania	A worker is entitled to payment of expenses for medical or other services if the expense is reasona-ble and necessarily incurred. This largely depends on the individual circumstances of each case.	No mechanism for approval of allied health providers. General guidelines about reimbursement for medical and other services. No mention of naturopaths or naturopathic services.
Accident Compensation (WorkCover Insurance) Act 1993 (VIC)	WorkSafe Victoria	Naturopathy is listed as an allied health profession and naturopaths may be registered as healthcare providers with WorkSafe Victoria.	Naturopaths must be eligible for full membership of specified professional associations and have a mini-mum of $1 million professional indemnity insurance. Three associations specified: Australian Natural Therapists Association Australian Natural Practitioners Association Complementary Medicine Association
Workers Compensation and Rehabilitation Act 1981 (WA)	WorkCover WA	Act and regulations recognise certain forms of treatment.	Naturopaths are not approved health providers; how-ever naturopathy may be deemed as 'reasonable' therapy. The website states: If a worker requires treatment from a non-approved health provider for example a naturopath, they should check with their employer's insurer to ensure that their cost will be reimbursed prior to commencing treatment.

APPENDIX 8.2: Transport/motor vehicle accident compensation arrangements by state and territory

State/territory Legislation	Regulator (with embedded website link)	Eligible providers	Status of naturopaths
Motor Accident Injuries Act 2019 (ACT)	Motor Accident Injuries Commission	A recovery plan may include reimbursement for 'ongoing reasonable and necessary treatment and care' under a treating doctor who is responsible for the coordination and management of a patient's treatment and recovery.	Nothing found on website about approved allied health providers or naturopaths.
Motor Accident Injuries Act 2017 (NSW) Motor Accidents Act 1988 (NSW) Motor Accidents Compensation Act 1999 (NSW)	NSW State Insurance Regulatory Authority (SIRA)		Nothing found on website about approved allied health providers or naturopaths.
Motor Accidents (Compensation) Act 1979 (NT)	NT Motor Accidents Compensation Commission	The website lists the benefits for the 'necessary and reasonable costs' for medical, hospital, and rehabilitation treatment of an injury sustained in a motor vehicle accident: Rehabilitation/Therapy services: including but not limited to physiotherapy, occupational therapy, chiropractic and psychological treatment. Medical treatment providers must be registered with the Australian Health Practitioner Regulation Authority (Ahpra) or the relevant state or national regulator.	The website states: Costs for treatment by unregistered service providers... are not covered.
National Injury Insurance Scheme (Queensland) Act 2016	National Injury Insurance Scheme, Queensland (NIISQ)	The website lists the treatment, care and support provided by the Scheme. The Scheme provides necessary and reason-able treatment, care and support for participants who sus-tain eligible serious personal injuries in a motor vehicle accident in Queensland on or after 1 July 2016. Treatment, care and support will be tailored to the individual, taking into consideration their unique and personal circumstances, and their personal goals.	The website states the ser-vices that are NOT covered, including: Services provided by a per-son who is not a registered provider, where required under the National Injury Insurance Scheme (Queens-land) Act 2016
Compulsory Third Party Insurance Regulation Act 2016 (SA)	CTP Insurance Regulator ReturntoWorkSA	The scheme provides compensation for reasonable and necessary medical treatment and services provided by an 'appropriately qualified allied health professional with recognised qualifications and registration, under an Allied Health Management Plan.	No reference to naturopaths as eligible to provide services under an Allied Health Management Plan.
Motor Accidents (Liabilities and Compensation) Act 1973 (TAS)	Motor Accidents Insurance Board	Website lists 'treating practitioners' as from the following professions: chiropractic, exercise physiology, osteopathy, physiotherapy. Also states: all service providers whose prac-tising speciality is governed by Ahpra are registered with this agency. Registration with Ahpra is verified before any pay-ment for services can be made.	No reference to naturo-paths as eligible to provide services under a Manage-ment Plan.
Transport Accident Act 1986 (VIC)	Transport Accident Commission	Service providers eligible to provide allied health services to a claimant under an Allied Health Treatment and Recovery Plan include chiropractors, osteopaths, acupuncturists and exercise physiologists.	Naturopathy is not listed as an allied health profession. Naturopaths may be regis-tered as healthcare provid-ers with the TAC.
Motor Vehicle (Third Party Insurance) Act 1943 (WA) Motor Vehicle (Catastrophic Injuries) Act 2016 (WA)	Insurance Com-mission of West-ern Australia	Health professionals already registered with the Australian Health Practitioner Regulation Agency (Ahpra) are not required to undergo an additional registration with the Insurance Commission to provide treatment, care and support services.	The website states that the Insurance Commission can use a provider who is not on the register to deliver a particular service. This of-ten occurs to cater for re-gional and remote areas of Western Australia and in exceptional circumstances.