The College of Naturopaths of Ontario

Council of the College of Naturopaths of Ontario

Meeting #44

Draft Agenda

Date: November 27, 2024 (2024/25-04)

Time: 9:15 a.m. to 12:00 p.m.

Location: Zoom Video Conference Platform[1]

[1] Pre-registration is required.

Excerpt from the Health Professions Procedural Code
Regulated Health Professions Act.

COLLEGE

College is body corporate

2. (1) The College is a body corporate without share capital with all the powers of a natural person.

Corporations Act

(2) The *Corporations Act* does not apply in respect to the College. 1991, c. 18, Sched. 2, s. 2.

Duty of College

2.1 It is the duty of the College to work in consultation with the Minister to ensure, as a matter of public interest, that the people of Ontario have access to adequate numbers of qualified, skilled and competent regulated health professionals. 2008, c. 18, s. 1.

Objects of College

3. (1) The College has the following objects:

1. To regulate the practice of the profession and to govern the members in accordance with the health profession Act, this Code and the *Regulated Health Professions Act, 1991* and the regulations and by-laws.
2. To develop, establish and maintain standards of qualification for persons to be issued certificates of registration.
3. To develop, establish and maintain programs and standards of practice to assure the quality of the practice of the profession.
4. To develop, establish and maintain standards of knowledge and skill and programs to promote continuing evaluation, competence and improvement among the members.
   4.1 To develop, in collaboration and consultation with other Colleges, standards of knowledge, skill and judgment relating to the performance of controlled acts common among health professions to enhance interprofessional collaboration, while respecting the unique character of individual health professions and their members.
5. To develop, establish and maintain standards of professional ethics for the members.
6. To develop, establish and maintain programs to assist individuals to exercise their rights under this Code and the *Regulated Health Professions Act, 1991*.
7. To administer the health profession Act, this Code and the *Regulated Health Professions Act, 1991* as it relates to the profession and to perform the other duties and exercise the other powers that are imposed or conferred on the College.
8. To promote and enhance relations between the College and its members, other health profession colleges, key stakeholders, and the public.
9. To promote inter-professional collaboration with other health profession colleges.
10. To develop, establish, and maintain standards and programs to promote the ability of members to respond to changes in practice environments, advances in technology and other emerging issues.
11. Any other objects relating to human health care that the Council considers desirable. 1991, c. 18, Sched. 2, s. 3 (1); 2007, c. 10, Sched. M, s. 18; 2009, c. 26, s. 24 (11).

Duty

(2) In carrying out its objects, the College has a duty to serve and protect the public interest. 1991, c. 18, Sched. 2, s. 3 (2).

The College of Naturopaths of Ontario

COUNCIL MEETING #44
November 27, 2024
9:15 a.m. to 12:00 p.m.
DRAFT AGENDA

Sect/No.	Action	Item		Page	Responsible
0	**Pre-Meeting Networking (8:00 am to 9:00 am)**				
	Networking	Information networking for Council members (8:45-9:15am)		--	All
1	**Call to Order and Welcome**				
1.01	Procedure	Call to Order		--	J. Sokoloski
1.02	Discussion	Meeting Norms		4-6	
1.03	Discussion	"High Five" – Process for identifying consensus		7	
2	**Consent Agenda**				
2.01	Approval	i.	Draft Meeting Minutes of September 25, 2024	8-12	J. Sokoloski
		ii.	Committee Reports	13-27	
		iii.	Information Items	28-165	
3	**Approval of Agenda and Conflicts of Interest**				
3.01	Approval	Review of Main Agenda		3	J. Sokoloski
3.02	Discussion	Declarations of Conflict of Interest		166-167	
4	**Monitoring Reports**				
4.01	Acceptance	Report of the Council Chair		168	J. Sokoloski
4.02	Acceptance	Report on Regulatory Operations at October 31, 2024		169-180	A Parr
4.03	Acceptance	Report on Operations – Mid-year Report		181-221	A Parr
4.04	Acceptance	Variance Report & Unaudited Financial Statements at Q2		222-231	A Kupny
5	**Council Governance Policy Confirmation**				
5.01	Discussion	Policy Issues Arising from Monitoring Reports[1]		--	J. Sokoloski
5.02	Review	Ends Policies, Council-CEO Linkage Policies		--	
5.03	Approval	WGIMPH Terms of Reference/GP06-Committee Principles		232-236	
6	**Regular Business**				
6.01	Information	Appointment of CEO Review Panel		--	A Kupny
6.02	Decision	Committee appointment - WGIMPH		--	J. Sokoloski
7	**Council Education**				
7.01	Briefing	Program Briefing – Inspection Program		237-240	J. Quesnelle
7.02	Briefing	Regulated Health Professions Act, 1991		--	R Durcan
8	**Other Business**				
8.01	TBD			--	
9	**Evaluation and Next Meeting**				
9.01	Discussion	Meeting Evaluation (Click here to complete the evaluation)		On-line	J. Sokoloski
9.02	Discussion	Next Meeting – January 29, 2025		--	
10	**Adjournment**				
10.01	Decision	Motion to Adjourn		--	J. Sokoloski

[1] Council considers the information provided in the monitoring reports and whether any changes or updates may be required to the Governance policies (Ends, Governance Process, CEO-Council Linkage, Executive Limitations policies)

The College of Naturopaths of Ontario

Zoom Meeting
Council of the College of Naturopaths of Ontario

Meeting Norms

General Norms

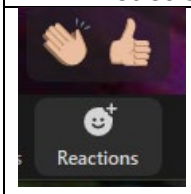
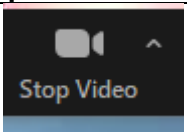
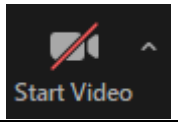
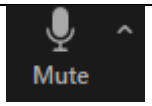
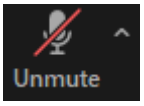
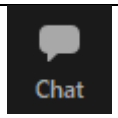
1. We'll listen actively to all ideas
2. Everyone's opinions count
3. No interrupting while someone is talking
4. We will be open, yet honor privacy
5. We'll respect differences
6. We'll be supportive rather than judgmental
7. We'll give helpful feedback directly and openly
8. All team members will offer their ideas and resources
9. Each member will take responsibility for the work of the team
10. We'll respect team meeting times by starting on time, returning from breaks promptly and, avoid unnecessary interruptions
11. We'll stay focused on our goals and avoid getting sidetracked

Additional Norms for Virtual Meetings

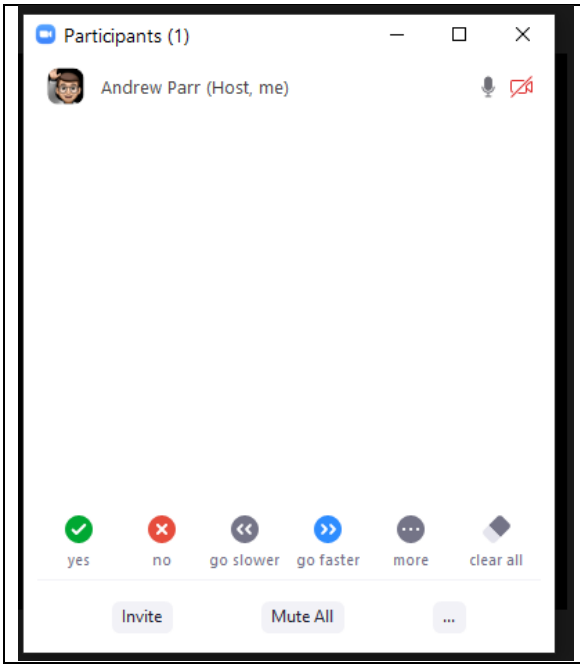
1. No putting the call on hold or using speakerphones
2. Minimize background noise – place yourself on mute until you are called upon to speak and after you have finished speaking
3. All technology, including telephones, mobile phones, tablets and laptops, are on mute or sounds are off
4. If we must take an emergency telephone call, we will ensure that we are on mute and we will stop streaming our video

5. Stay present – webcams will remain on (unless we are on a call or there is another distraction on your end)
6. Stay focused – avoid multi-tasking during the meeting
7. Use reactions (thumbs up, applause) to celebrate accomplishments and people
8. Use the Chat feature to send a message to the meeting host or the entire group.

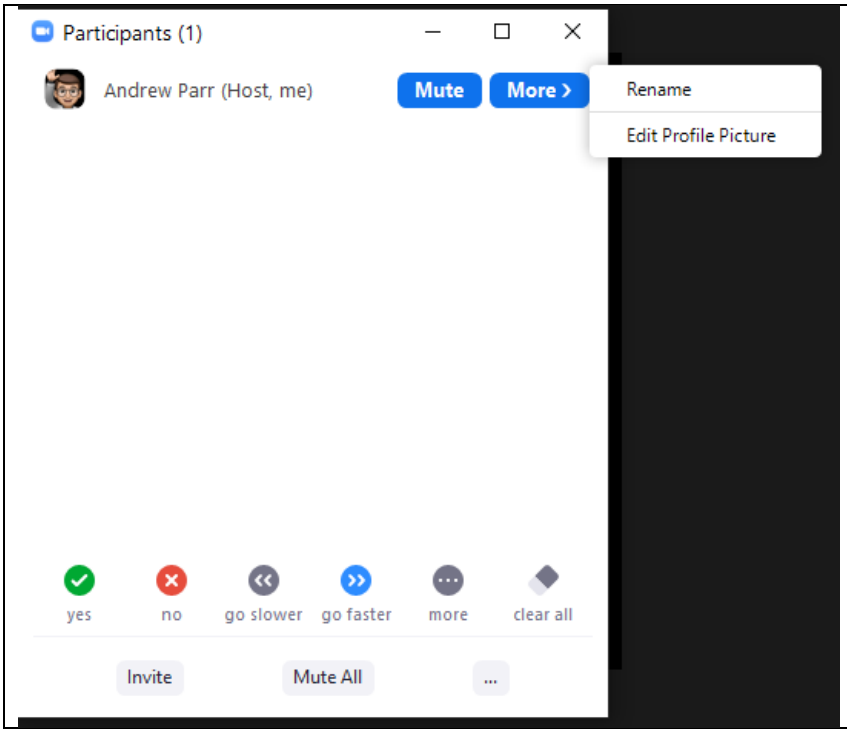
Zoom Control Bar – Bottom of screen

Reactions	Stop or Start Video	Mute/Unmute	
	 	 	

Other Helpful Tips



- Use the Participants button on the bottom control button to see a list of participants.
- On the Participants Menu, you can use the bottoms to send instant message to the Host… yes or no etc. (Not all of these options will appear if you are not the Host)



- Hover over your name on the Participants list to get more options
- You can rename yourself to your proper name
- You can add or change a profile picture.

The College of Naturopaths of Ontario

Zoom Meeting
Council of the College of Naturopaths of Ontario

Using "High Five" to Seek Consensus

Image provided courtesy of Facilitations First Inc.

We will, at times, use this technique to test to see whether the Council has reached a consensus.

When asked you would show:

- 1 finger – this means you hate it!
- 2 fingers – this means you like it but many changes are required.
- 3 fingers – this means I like it but 1-2 changes are required.
- 4 fingers – this means you can live with it as is.
- 5 fingers – this means you love it 100%.

In the interests of streamlining the process, for virtual meetings, rather than showing your fingers or hands, we will ask you to complete a poll.

The College of Naturopaths of Ontario

Council Meeting
September 25, 2024

Video Conference
DRAFT MINUTES

Council		
Present		**Regrets**
Dr. Felicia Assenza, ND (3:3)		Dr. Brenda Lessard-Rhead, ND (Inactive) (1:3)
Dr. Amy Dobbie, ND (3:3)		Dr. Jacob Scheer, ND (1:3)
Mr. Dean Catherwood (2:3)		
Mr. Brook Dyson (3:3)*		
Ms. Lisa Fenton (3:3)		
Ms. Sarah Griffiths-Savolaine (3:3)		
Dr. Denis Marier, ND (3:3)		
Mr. Paul Philion (3:3)		
Dr. Jordan Sokoloski, ND (3:3)		
Dr. Erin Walsh (Psota), ND (2:3)		
Staff Support		
Mr. Andrew Parr, CAE, CEO		
Ms. Agnes Kupny, Director, Operations		
Ms. Erica Laugalys, Deputy CEO, Registrant and Corporate Services		
Mr. Jeremy Quesnelle, Deputy CEO, Regulation		
Ms. Monika Zingaro, Human Resources Coordinator		
Guests		
Ms. Rebecca Durcan, Legal Counsel		
Mr. Barry Sullivan, GPRC Acting Chair		

*Joined at 9:50 a.m.

1. Call to Order and Welcome
The Chair, Dr. Jordan Sokoloski, ND, called the meeting to order at 9:16 a.m. He welcomed everyone to the meeting.

The Chair noted that the meeting was being live streamed via YouTube to the College's website.

2. Consent Agenda
2.01 Review of Consent Agenda
The Consent Agenda was circulated to members of Council in advance of the meeting. The Chair asked if there were any items to move to the main agenda for discussion. There were none.

MOTION:	To approve the Consent Agenda as presented.
MOVED:	Dean Catherwood
SECOND:	Paul Philion
CARRIED.	

3. Main Agenda
3.01 Review of the Main Agenda
A draft of the Main Agenda, along with the documentation in support of the meeting had been circulated in advance of the meeting. The Chair asked if there were any items to be added to the agenda. There were none.

MOTION:	To approve the Main Agenda as presented.
MOVED:	Denis Marier
SECOND:	Sarah Griffiths-Savolaine
CARRIED.	

3.02 Declarations of Conflicts of Interest
The Chair reminded the Council members of the updated Declarations of Conflict-of-Interest process. A summary of the Annual Conflict of Interest Questionnaires completed by Council members have been included in the Council package to increase transparency and accountability initiatives, and to align with the College Performance Measure Framework Report (CPMF) launched by the Ministry of Health.

4. Monitoring Reports
4.01 Report of the Council Chair
The Report of the Council Chair was circulated in advance of the meeting. The Chair reviewed the report with Council. He welcomed and responded to questions from the Council.

MOTION:	To accept the Report of the Council Chair as presented.
MOVED:	Lisa Fenton

SECOND:	Erin Walsh (Psota)
CARRIED.	

4.02 Report on Regulatory Operations from the Chief Executive Officer (CEO)
The Report on Regulatory Operations at August 31, 2024 from the CEO was circulated in advance of the meeting. Mr. Parr provided highlights of the report and responded to questions that arose during the discussion that followed.

MOTION:	To accept the Report on Regulatory Operations at August 31, 2024 from the CEO.
MOVED:	Paul Philion
SECOND:	Dean Catherwood
CARRIED.	

4.03 Unaudited Financial Statements at Q1
A copy of the Unaudited Financial statements ending June 30, 2024 (Q1) were included in the materials circulated in advance of the meeting. Ms. Agnes Kupny, Director, Operations, provided a detailed review of the Statements and highlighted changes in the report from the previous quarters. She responded to questions that arose during the discussion that followed.

MOTION:	To accept the Variance Report and the Unaudited Financial Statements for the first quarter as presented.
MOVED:	Dean Catherwood
SECOND:	Amy Dobbie
CARRIED.	

5. Council Governance Policy Confirmation
5.01 Review/Issues Arising
5.01(i) Council-CEO Linkage Policies
Council members were asked if they had any questions or matters to note with respect to the Council-CEO Linkage policies based on the reports received. No issues were noted at this time.

5.01(ii) Governance Process Policies
Council members were asked if they had any questions or matters to note with respect to the Governance Process policies based on the reports received. No issues were noted at this time.

5.01(iii) Ends Policies
Council members were asked if they had any questions or matters to note with respect to the Ends policies based on the reports received. No issues were noted at this time.

5.02 Detailed Review (as per GP08) – Executive Limitations Policies (Part 2)
Mr. Barry Sullivan, Governance Policy Review Committee (GPRC), Acting Chair, provided the Council with a detailed presentation reviewing EL09 through EL17 and highlighted each policies

directives and reviewed the results of the survey completed by Council in relation to the grouping of policies.

Council members were asked if there were any members who wished to discuss the Executive Limitations Policies (Part 2), and Mr. Sullivan and Mr. Parr responded to any questions that arose during the discussion.

5.03 Proposed Policy Amendments
Mr. Sullivan, GPRC Acting Chair, highlighted proposed amendments to various Governance Process (GP) Policies, GP 08, GP 21, GP 26, GP 27, GP 28, GP 30 and GP 31, and Executive Limitations (EL) Policy EL17.

Mr. Sullivan and Mr. Parr responded to any questions that arose during the discussion.

MOTION:	To accept the recommendations of the Governance Policy Review Committee to amended GP 08, GP 21, GP 26, GP 27, GP 28, GP 30, GP 31, and EL17 as presented.
MOVED:	Paul Philion
SECOND:	Amy Dobbie
CARRIED.	

6. Business
6.01 Organizational Structure of the College
A Briefing Note explaining the updated organizational structure of the College was circulated to the Council in advance of the meeting. Mr. Parr provided the Council members with a thorough explanation of the changes to the organizational structure found within the Human Resources Plan previously accepted by Council at their March 2024 meeting, which was developed to assist in the achievement of several important goals for the College through the Council's Strategic Plan.

In addition, he provided an overview of two new Human Resources Programs that will be implemented in the next fiscal year for all staff. Mr. Parr responded to any questions that arose during the discussion.

MOTION:	To receive the Organizational Structure changes and the Human Resources Program materials from the CEO.
MOVED:	Paul Philion
SECOND:	Denis Marier
CARRIED.	

7. Council Education
7.01 Program Briefing – Quality Assurance Program
A Briefing Note highlighting the Quality Assurance Program was circulated in advance of the meeting. Mr. Jeremy Quesnelle, Deputy CEO, Regulation, provided a presentation explaining

the three main components of the program with detailed examples and responded to any questions posed by Council.

7.02 Communication Key Messages
A memorandum developed to provide Council members with key messages to be used when engaging or responding to registrants and members of the public was circulated in advance of the meeting.

Mr. Parr informed the Council that these messages were distributed to provide Council members with information and guidelines to respond to inquires while maintaining the structure set out in the Governance Process policies of the Council.

In addition, Mr. Parr provided some scenarios in which the messaging presented can be used and responded to any questions that arose during the discussion.

8. Other Business
The Chair asked if there was any other business to be brought before the meeting ended. There was none.

9. Meeting Evaluation and Next Meeting
9.01 Meeting Evaluation
The Chair advised the Council members that a link will be provided within the chat feature via Zoom for each member to copy and paste into a web browser or to use the link embedded on the Main Agenda to complete an evaluation form immediately following the end of the meeting.

9.02 Next Meeting
The Chair noted for the Council that the next regularly scheduled meeting is set for November 27, 2024. This meeting will be held virtually via video conference.

10. Adjournment
10.01 Motion to Adjourn
The Chair asked for a motion to adjourn the meeting. The meeting adjourned at 11:38 a.m.

MOTION:	To adjourn the meeting.
MOVED:	Paul Philion
SECOND:	Erin Walsh (Psota)

Recorded by: Monika Zingaro
Human Resources Coordinator
September 25, 2024

The College of Naturopaths of Ontario

MEMORANDUM

DATE: November 20, 2024

TO: Council members

FROM: Andrew Parr, CAE
Chief Executive Officer

RE: Committee Reports

Please find attached the Committee Reports for item 2.01 (ii) of the Consent Agenda. The following reports are included:

1. Audit Committee
2. Discipline Committee
3. Equity, Diversity and Inclusion Committee
4. Examination Appeals Committee
5. Executive Committee
6. Governance Committee
7. Governance Policy Review Committee
8. Inquiries, Complaints and Reports Committee
9. Inspection Committee
10. Patient Relations Committee
11. Quality Assurance Committee
12. Registration Committee
13. Standards Committee

In order to increase the College's accountability and transparency, all Committee Chairs were asked to submit a report, even if the Committee had not met during the reporting period. Please note the Discipline/Fitness to Practise Committee Chair was not required to submit a report in order to preserve the independent nature of these Committees; however, the Chair has voluntarily provided a report for Council's information.

The College of Naturopaths of Ontario

AUDIT COMMITTEE REPORT
Period of September 1, 2024, to October 31, 2024

This serves as the chair report of the Audit Committee for the period July 1, 2024, to August 31, 2024. During the reporting period the Audit Committee did not meet. The committee is scheduled to meeting again in May 2025 to begin the audit for the 2024-2025 fiscal year.

Respectfully submitted,

Brook Dyson
Chair
November 2024

The College of Naturopaths of Ontario

DISCIPLINE COMMITTEE REPORT
Period of September 1, 2024 to October 31, 2024

The Discipline Committee (DC) is independent of Council and has no legal obligation to submit bimonthly reports addressing matters of importance to the Committee. However, in the interest of transparency and to acknowledge Committee members' involvement in the discipline process, the Chair is pleased to provide this report to Council.

This report is for the period from 1 September to 31 October 2024 and provides a summary of the hearings held during that time as well as any new matters referred to the DC by the Inquiries, Complaints and Reports Committee (ICRC) of the College. Committee meetings and training are also reported.

Overview

As of October 31, 2024, there were two ongoing discipline matters before the Committee (DC22-04 and 22-05).

Discipline Hearings and Decisions & Reasons

Continuation of file DC22-04 involving Dr. Michael Prytula, ND, was held on September 13, 2024.

Continuation of file DC22-05 involving Dr. Michael Um, ND, was held on September 4, 5 and 15, 2024.

Both hearings have now completed and the Panels are currently working on their Decisions and Reasons with respect to the matters.

New Referrals

No new referrals were made to the Discipline Committee from the ICRC during the reporting period.

Committee Meetings and Training

There were no Committee meetings held during the reporting period.

Respectfully submitted,
Dr. Jordan Sokoloski, ND, Chair
November 18, 2024

The College of Naturopaths of Ontario

EQUITY, DIVERSITY, INCLUSION AND BELONGING COMMITTEE REPORT

Period of September 1, 2024 to October 31, 2024

For the reporting period of September 1 to October 31, 2024, the Equity, Diversity, Inclusion and Belonging Committee met once on October 9, 2024. The Committee reviewed and provided feedback on a draft EDIB Self-Assessment and discussed the various approaches to drafting a meaningful land acknowledgement. The EDIB Committee continues to encourage all College Committees to utilize the EDIB Lens Tool during their meetings.

The Committee is next scheduled to meet on February 12, 2025.

Respectfully submitted,

Dr. Jamuna Kai, ND
Co-Chair
November 2024

Dr. Shelley Burns, ND
Co-Chair
November 2024

The College of Naturopaths of Ontario

EXAM APPEALS COMMITTEE CHAIR REPORT

September 1 - October 31, 2024

The Committee meets on an as-needed basis, based on received exam appeals, those that would require deliberation and decision, or needed appeals-related policy review.

The Exam Appeals Committee did not meet during this reporting period.

Respectfully,

Rick Olazabal, ND (Inactive)

Chair

Exam Appeals Committee

November 4, 2024

The College of Naturopaths of Ontario

EXECUTIVE COMMITTEE REPORT
Period of September 1, 2024 to October 31, 2024

This serves as the Chair report of the Executive Committee for the period of September 1 to October 31, 2024.

During the reporting period the Executive Committee was not required to undertake any activities, and therefore did not convene.

Respectfully submitted,

Dr. Jordan Sokoloski, ND
Council Chair
18 November 2024

The College of Naturopaths of Ontario

GOVERNANCE COMMITTEE REPORT
Period of September 1, 2024 to October 31, 2024

This serves as the chair report of the Governance Committee for the period September 1, 2024, to October 31, 2024. During the reporting period the Governance Committee did not meet, the Committee is scheduled to meet again on November 26, 2024.

Respectfully submitted,

Hanno Weinberger
Chair
November 4, 2024

The College of Naturopaths of Ontario

GOVERNANCE POLICY REVIEW COMMITTEE REPORT

For the period September 1, 2024 to October 31, 2024

Meetings and Attendance

During this period, the Governance Policy Review Committee met on two occasions via video conference, on September 10th and October 28th respectively. There were no concerns regarding quorum.

Activities Undertaken

At its **September** meeting, the Committee first confirmed its approach and reviewed questions for inclusion in the survey to be sent to and completed by Council members in preparation for their in- depth review of the Governance Policies- Executive Limitation Policies (Part Two) at their upcoming meeting on September 25,2024.

In addition, the Committee completed their regular review of the Governance Process Policies (GP) Part 5 and finalized proposed changes to GP08, GP21, GP26, GP27, GP28, GP30, and GP31, to be submitted to Council for approval at their next meeting. An amendment to the Executive Limitation policy EL17, as proposed by the CEO, was also discussed and accepted by the Committee for inclusion in the aforementioned package going forward to Council.

At the **October** meeting, the Committee first reviewed feedback from Council members with respect to its approach toward assisting Council members with their review of Governance Policies in preparation for the subsequent in-depth reviews taking place at Council meetings. The Committee decided that some modifications to the process would be in order and subsequently arrived at a plan as to what would be sent to Council members in advance of the in-depth review of the Governance Policies-Ends Statements and Council-CEO Linkage policies to be completed at the November Council meeting.

In addition, the Committee reviewed and provided comment on the proposed Terms of Reference for a new 'Working Group on the Identification and Mitigation of Patient Harm', as tabled by the CEO. The 'Group' would be sponsored and supported by CONO and comprised of up to 2 representatives, appointed from each of: CONO; the OAND; CCNM and the Ministry of Health. Consensus of the Committee was that it should be recommended to Council that this be designated as a Council Working Group rather than an Operational Working Group.

The Committee next reviewed its policy review schedule, deciding that it would proceed with its review of the Committee Terms of Reference policies over the next three meetings.

Finally, the Committee reviewed and after making one minor meeting date change, accepted the 2025 Meeting Schedule proposed by staff.

Next Meeting Date:
January 7, 2025

Respectfully submitted:

Barry Sullivan/ Jordan Sokoloski
Acting Chairs
November 13, 2024

The College of Naturopaths of Ontario

INQUIRIES, COMPLAINTS AND REPORTS COMMITTEE REPORT
Period of September 1, 2024 to October 31, 2024

Between September 1 and October 31, 2024, the Inquiries, Complaints and Reports Committee held two regular online meetings – September 12 and October 3.

September 12, 2024: 6 matters were reviewed, ICRC members approved 2 Decisions and Reasons.

October 3, 2024: 4 matters were reviewed, ICRC members drafted 2 reports for ongoing investigations. Additionally, the ICRC delivered one oral caution to a registrant previously ordered by the Committee.

Respectfully submitted,

Dr. Erin Psota, ND
Chair
November 13th, 2024

The College of Naturopaths of Ontario

IVIT Inspection Committee Report
Period of September 1st to October 31st, 2024

Committee Update

The Inspection Committee has met once by teleconference on September 19th, 2024.

Inspection Outcomes

Part I inspections – two passes with 6 recommendations

Part II inspections – one pass with 4 recommendations

5-year inspections – one pass with 2 conditions and 8 recommendations

Inspection Outcomes to Submissions – There were three submissions with conditions changed to passes after the conditions had been met, a Part 1, Part II and 5-year inspection. There was a fourth submission from a 5-year inspection that remains a pass with conditions until a further inspection has been completed.

Two Deferrals of 90 days were granted.

Two type 1 occurrences were reviewed for referrals to emergency, no further action was required.

As the year draws to an end, I give thanks to another safe year of outcomes and a dedicated IVIT Inspection Committee. It is also an important time to remember our Veterans and their sacrifices for all of us. Lest we forget.

Respectfully submitted,

Dr Sean Armstrong ND
Chair
November 11th, 2024

The College of Naturopaths of Ontario

PATIENT RELATIONS COMMITTEE CHAIR REPORT
Period of September 1, 2024 to October 31, 2024

During the reporting period the Patient Relations Committee was not scheduled to meet.

The Committee's next scheduled meeting is November 20, 2024.

Respectfully submitted

Dr. Gudrun Welder, ND
Chair
November 2024

The College of Naturopaths of Ontario

QUALITY ASSURANCE COMMITTEE REPORT

For the period September 1, 2024 to October 31, 2024

Meetings and Attendance

Since the date of our last report to Council in September, the Quality Assurance Committee has met on two occasions via videoconference, on September 17th and October 29th, respectively. There were no concerns regarding quorum.

Activities Undertaken

Over these past two meetings, the Committee continued with its regular ongoing review and approval where appropriate, of new and previously submitted CE category A credit applications.

At it's **September** meeting, the Committee also reviewed and made a decision with respect to one CE reporting amendment request.

At its **October** meeting, the Committee reviewed and made decisions with respect to one CE Reporting amendment request and two Peer and Practice Assessment date-extension requests.

The Committee also reviewed and provided comments on both a proposed new Currency Hours Self-Assessment and the previously proposed EDIB Self-Assessment, since updated by staff.

In addition, the Committee reviewed and discussed the information contained in its QAC Annual Report for 2023/24, as well as related comparative report data information for the last three years, as presented by staff.

The Committee also reviewed and discussed an update provided by staff on the results of the Group 1 CE Reporting that was due for submission by September 30, 2024. The Committee decided that those registrants found to have discrepancies in their log form submissions, ie. missing credits, would be granted an extension until February 28, 2025 to remedy the situation.

Finally, they reviewed and accepted a proposed meeting schedule for 2025 as proposed by staff.

Next Meeting Date
December 3, 2024

Respectfully submitted by,
Barry Sullivan, Chair

November 12, 2024

The College of Naturopaths of Ontario

REGISTRATION COMMITTEE REPORT
Period of September 1, 2024 to October 31, 2024

At the time of this report, the Registration Committee met twice on September 19, 2024 and October 22, 2024.

Applications For Registration
The Committee reviewed one application for registration under subsections 5(2) and 5(4)(a) of the Registration Regulation to determine eligibility for registration with the College.

Currency Audit – Refresher Program
The Committee reviewed six proposed refresher program submissions under subsection 6(2)(a) of the Registration Regulation.

Class Change Application Inactive to General Class (over two years)
The Committee reviewed a Registrant's request for a class change application from Inactive to General (over two years), under subsection 10(6)(i) of the Registration Regulation.

Exam Remediation – Ontario Clinical Science Examination
The Committee reviewed and set plans of exam remediation for one candidate who had made two unsuccessful attempts at the Ontario Clinical Science Examination, in accordance with subsection 5(4)(b)(ii) of the Registration Regulation.

Exam Remediation – Ontario Clinical (Practical) Examination
The Committee reviewed and set plans of exam remediation for one candidate who had made two unsuccessful attempts at the Ontario Clinical (Practical) Examination, in accordance with subsection 5(4)(b)(ii) of the Registration Regulation.

Exceeded Exam Attempts – Ontario Clinical Science Examination
The Committee reviewed a petition for an additional examination attempt on the grounds of exceptional circumstances under subsection 5(5)(b) of the Registration Regulation.

Exam Remediation (Extension) – Ontario Prescribing & Therapeutics Examination
The Committee reviewed an extension request for completion of exam remediation related to the Ontario Prescribing & Therapeutics Examination, in accordance with subsection 5(4)(b)(ii) of the Registration Regulation.

Opening and Closing the Emergency Class Policy
The Committee reviewed the draft Opening and Closing of the Emergency Class policy. This class only opens a) if The Minister of Health requests that the College initiate registrations under this class based on the Minister's opinion that emergency circumstances call for it, or b) the Council has determined, after taking into account all of the relevant circumstances that impact the ability of applicants to meet the ordinary registration requirements, that there are emergency circumstances, and that it is in the public interest that the College issue emergency certificates.

Supervision Policy
The Committee reviewed the draft Supervision policy. The purpose of the policy is to ensure a more robust policy to speak to the requirements of the supervisor and supervisee, particularly as the Emergency class is a supervised class of registration.

Refresher Program Guideline and Charts
The Committee reviewed the draft Refresher Program Guideline and Charts and agreed that the guideline and charts set out a more objective, clear and concise criteria of what is expected of registrants and allows for a more structured approach to refresher programs for registrants to complete.

Respectfully submitted,

Danielle O'Connor ND
Chair
November 13, 2024

The College of Naturopaths of Ontario

STANDARDS COMMITTEE REPORT
Period of September 1, 2024 to October 31, 2024

During the reporting period the Standards Committee was not scheduled to meet as it awaits the conclusion of the public consultation of the proposed amended Standards of Practice.

The Committee is next scheduled to meet on November 13, 2024 to review the consultation feedback.

Respectfully submitted,

Dr. Elena Rossi, ND
Chair
November 2024

The College of Naturopaths of Ontario

MEMORANDUM

DATE: November 20, 2024

TO: Council members

FROM: Andrew Parr, CAE
Chief Executive Officer

RE: Items Provided for Information of the Council

As part of the Consent Agenda, the Council is provided several items for its information. Typically, these items are provided because they are relevant to the regulatory process or provide background to matters previously discussed by the Council.

To ensure that Council members, stakeholders and members of the public who might view these materials understand the reason these materials are being provided, an index of the materials and a very brief note as to its relevance is provided below.

As a reminder, Council members can ask that any item included in the Consent Agenda be moved to the main agenda if they believe the items warrants some discussion. This includes the items provided for information.

No.	Name	Description
1.	Grey Areas (No. 295 & 296)	Gray Areas is a monthly newsletter and commentary from our legal firm, Steinecke Maciura LeBlanc on issues affecting professional regulation. The issues for this past quarter are provided to Council in each Consent Agenda package.
2.	Legislative Update (September 2024, October 2024)	This is an update provide by Julie Maciura to the members of the Health Profession Regulators of Ontario (HPRO). The updates identify legislation or regulations pertaining to regulations that have been introduced by the Ontario Government.
3.	Council Meeting Evaluation	Tables summarizing the responses of Council member's feedback from the July 2024 Council meeting.

No.	Name	Description
4.	WHO Health Practitioner Regulation	Regulatory frameworks and appropriate regulation of health professionals were identified as critical elements of the WHO's Global Strategy on Human Resources for Health. This document speaks to effective public policy stewardship, leadership and governance through regulation of health professions.
5.	CANRA Announcement	CANRA has announced that all member jurisdictions have adopted the National Entry-to-Practice Competencies for NDs.
6.	Policy Amendments	The Council amended the Terms of Reference for the Statutory Committees delegating them the authority to oversee the administration of their relevant programs. As such, the Committees are now authorized to amend Program Policies, however, these must be disclosed to the Council. In this section, a supervision policy and opening and closing of the emergency class policies are provided for the Council's information. These policies were approved by the Registration Committee on October 22, 2024.

STEINECKE MACIURA LEBLANC

GREY AREAS NEWSLETTER

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

sml-law.com/resources/grey-areas/

Lack of Remorse vs. Degree of Insight – Part 1

by Natasha Danson

October 2024 - No. 295

Despite some strong pronouncements from the courts, ambiguity remains for disciplinary panels considering a lack of "remorse" by a registrant when imposing sanctions.

Part of the confusion likely results from importing criminal sentencing principles into the professional misconduct realm. Even the word "remorse" conjures up concepts of moral blameworthiness, rather than focussing on the public protection goals of the misconduct process. A more neutral term might be the absence of "acknowledgement".

The primary concern about imposing a harsher sanction on registrants who do not acknowledge the unprofessionalism of their conduct is that it undermines their right to have the regulator prove the allegations against them. Indeed, where the difference in sanction is significant for those who do not admit the allegations as compared to those who do, some registrants may feel pressured to admit to false allegations; *Quaidoo v Edmonton (Police Service)*, 2015 ABCA 381 (CanLII).

As a result, many courts have long stated that it is a reversible error of law for a hearing panel to treat a lack of acknowledgement by the registrant as an aggravating factor justifying a more serious sanction: *College of Physicians and Surgeons of Ontario v. Gillen*, 1993 CanLII 8641 (ON CA), *College of Physicians and Surgeons of Ontario v. Boodoosingh* (H.C.J.), 1990 CanLII 6686 (ON SC), affirmed 1993 CanLII 8655 (ON CA); *Kuny v College of Registered Nurses of Manitoba*, 2018 MBCA 21 (CanLII).

But what about registrants who recognize their error, acknowledge their conduct, and demonstrate an intention to alter their future behaviour? Courts agree that this should be considered when imposing sanction and have created a kind of legal distinction that can be difficult to follow. While a lack of acknowledgement is not an aggravating factor, sincere acknowledgement is a mitigating factor justifying a lesser sanction than would otherwise be appropriate. As worded in *Dr. Jha v. College of Physicians and Surgeons of Ontario*, 2022 ONSC 769 (CanLII):

> Although some might say that the distinction between the presence of an aggravating factor and the absence of a mitigating factor is a fine one, it is a distinction well recognized both in the professional discipline and in the criminal law context….

As a result, when looking at precedent cases, a registrant who has not acknowledged their unprofessional conduct is not similarly situated to a registrant who has: *Kitmitto v. Ontario (Securities Commission)*, 2024 ONSC 1412 (CanLII); *Wong v. Real Estate Council of British Columbia*, 2004 BCCA 120 (CanLII); *Moonshiram v. College of Immigration and Citizenship Consultants*, 2024 FC 1212 (CanLII).

It seems this distinction does not always apply. Certainly, where a registrant maintains a defence of having acted in good faith (e.g., maintaining the correctness of their exercise of judgment, say in the treatment of a patient, when the hearing panel finds that the approach was misguided), the lack of acknowledgement is fairly consistently not treated as an aggravating factor: *Breger v. Physicians (Professional Order of)*, 2019 QCTP 106 (CanLII). Similarly, maintaining throughout a discipline hearing a good faith refusal to cooperate in an investigation based on a honest misapprehension of the registrant's rights was not treated as an aggravating factor in *D'Mello v The Law Society of Upper Canada*, 2015 ONSC 5841 (CanLII).

However, there are several instances where courts condoned imposing a severe sanction based, at least in part, on a bad faith denial of the allegations: *Benhaim c. Médecins (Ordre professionnel des)*, 2019 QCTP 115 (CanLII); *Byrnes v Law Society of Upper Canada*, 2015 ONSC 2939 (CanLII); *Mailloux c. Médecins (Ordre professionnel des)*, 2013 QCTP 43 (CanLII), affirmed 2014 QCCS 1594 (CanLII), affirmed 2016 QCCA 62 (CanLII), leave to appeal refused 2016 CanLII 41049 (CSC).

Similarly, courts have sometimes tolerated the imposition of a more severe sanction where the registrant was found not to be credible when testifying: *Gibbon v. Justice of the Peace Review Council*, 2023 ONSC 5797 (CanLII); *Taylor v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 4562 (CanLII).

Two additional critical points need to be made. First, courts have accepted that a lack of insight by the registrant is relevant to the sanction that should be imposed. Obviously, prioritizing remedial terms, conditions, and limitations over specific deterrence measures such as a longer suspension or revocation is justifiable where the registrant has insight into their conduct and how they need to conduct themselves in future.

However, is there a distinction between a lack of acknowledgement of the conduct and lack of insight on the part of the registrant? Several court decisions appear to find a difference even where the lack of insight is partially based on the registrant's denial of the allegations at the hearing: *Gibbon v. Justice of the Peace Review Council*, 2023 ONSC 5797 (CanLII); *Yazdanfar v. The College of Physicians and Surgeons*, 2013 ONSC 6420 (CanLII); *Peet v Law Society of Saskatchewan*, 2019 SKCA 49 (CanLII); *Abrametz v The Law Society of Saskatchewan*, 2018 SKCA 37 (CanLII).

Similarly, a failure to recognize the inappropriateness of the conduct is an indication of likelihood to reoffend unless a significant sanction is imposed. Thus, the registrant's attitude towards their conduct can sometimes be considered an aggravating factor, if framed as demonstrating an increased risk of recurrence. For example, in *Massiah v Justices of the Peace Review Council*, 2016 ONSC 6191 (CanLII), the Court said:

> … the 2012 Panel did not punish the applicant for contesting the

> allegations. Rather, having concluded that the misconduct had occurred, it found that the applicant did not have insight into his misconduct and, therefore, the 2012 Panel could not have any faith that the misconduct would not be repeated.

See also: *Terjanyan c. Lafleur*, 2019 QCCA 230 (CanLII); *Librandi c. Chartered Professional Accountants (Ordre des)*, 2023 QCTP 7 (CanLII); and *Karkar v. Professions Tribunal*, 2017 QCCS 4345 (CanLII), leave to appeal denied 2017 QCCA 1619 (CanLII).

Based on these decisions, a "nuanced" approach to lack of acknowledgement by a registrant might be summarized as follows:

1. A registrant's lack of acknowledgement cannot be treated as an aggravating factor on sanction.
2. However, it can be treated as the absence of a mitigating factor depriving the registrant of leniency that they might otherwise receive.
3. Some exceptions might be made where the registrant takes a bad faith approach to disputing the allegations.
4. A lack of insight can be viewed as relevant to the severity and nature of the sanction imposed even if it is based, in part, on the registrant's approach to the allegations.
5. A registrant's approach to the allegations might also be relevant to the likelihood of the registrant repeating the conduct which can reasonably affect the severity and nature of the sanction.

The approach by courts to a lack of acknowledgement has been technical, not entirely consistent, and is extremely difficult for discipline panels to apply.

Perhaps it is time to revisit the issue entirely. Rather than using a modified criminal sentencing approach, could a fresh professional regulation approach be developed?

In Part 2 we will look at a "degree of insight" approach to sanctioning registrants.

FOR MORE INFORMATION
This newsletter is published by Steinecke Maciura LeBlanc, a law firm practising in the field of professional regulation. If you are not receiving a copy and would like one, please visit our website to subscribe: https://sml-law.com/resources/grey-areas/

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GREY AREAS NEWSLETTER

A COMMENTARY ON LEGAL ISSUES AFFECTING PROFESSIONAL REGULATION

sml-law.com/resources/grey-areas/

Lack of Remorse vs. Degree of Insight – Part 2

by Natasha Danson

November 2024 - No. 296

In Part 1 of this article, we examined how Canadian courts have approached a registrant's lack of remorse for (or "acknowledgement" of) allegations when imposing disciplinary sanctions. We posited that the approach has been technical, inconsistent, and difficult to apply. In this article we propose that a "degree of insight" approach can sidestep the issue and bring a principled approach to discipline panels crafting suitable sanctions for professional misconduct. We believe the kernel of this modified approach is already found in some of the existing case law.

A recent decision in the United Kingdom indicates that a different approach to sanctioning "unfitness to practise" is developing there. In *Higgins v General Medical Council* [2024] EWHC 1906 (Admin) findings of sexual harassment (mostly verbal rather than physical) of junior colleagues were made against a physician. The physician vigorously disputed the allegations. When almost all the allegations were found to have been established, the physician asserted that they had gained insight through the process and from the remedial and therapeutic steps they had already undertaken. Despite this assertion, the tribunal revoked the physician's registration and he appealed both the findings and the sanction.

The Court upheld the decision and in doing so the Court acknowledged that the physician should not be punished for defending themselves. However, the Court discussed, at length, the issue of how disciplinary panels should apply the concept of insight.

First, the Court noted that the regulator had established detailed guidelines on how insight should affect sanction. In particular, the guidelines were described by the Court as follows:

> The Tribunal is to consider and balance any mitigating and aggravating factors (paras 24 – 60). The Guidance states the following in relation to insight:

> "45. Expressing insight involves demonstrating reflection and remediation.
>
> 46. A doctor is likely to have insight if they:
>
> a. accept they should have behaved differently (showing empathy and understanding)
> b. take timely steps to remediate (see paragraphs 31 – 33) and apologise at an early stage before the hearing
> c. demonstrate the timely development of insight during the investigation and hearing."
>
> Paragraph 31 says that "Remediation is where a doctor addresses concerns about their knowledge, skills, conduct or behaviour" and goes on to describe the forms that it can take. Lack of insight is identified as an aggravating factor at para 51, the Guidance then continues:
>
> "52. A doctor is likely to lack insight if they:
>
> a. refuse to apologise or accept their mistakes
> b. promise to remediate, but fail to take appropriate steps, or only do so when prompted immediately before or during the hearing
> c. do not demonstrate timely development of insight
> d. fail to tell the truth during the hearing…"

For our purposes, the particularly noteworthy aspects of the guidelines are that:

1. a lack of insight can be an aggravating factor on sanction and
2. a lack of insight can be based, at least in part, on the registrant's approach to the allegations before, during, and after the hearing. The tribunal was entitled to take the registrant's denials and other statements into account when assessing insight.

The Court also accepted the regulator's submission that there are degrees of insight. One level is an intellectual acceptance of the rules and their rationale. A higher level of insight involves a physician applying the relevant rules to their conduct. This includes accepting that they did not conform to the rules, why they did not do so, and what would be necessary to prevent future breaches. Insight exists on a continuum.

The Court indicated that the physician's continuing denial on appeal of many of the factual allegations and the conclusions drawn from them demonstrated an ongoing lack of significant insight. The Court did not see this conclusion as being unfair to the physician's ability to defend themselves.

The Court also saw the lack of insight as relevant to the physician's likelihood of repeating the conduct.

Perhaps it is also time, in Canada, to limit the principle of not treating a lack of remorse as an aggravating factor and instead limit it to the recognition that registrants should not be punished for disputing the allegations. The focus can then turn to the degree of insight of the registrant. Regulators should then be able to use all relevant information before it to assess the degree of insight of the registrant in designing a sanction that protects the public, facilitates the rehabilitation of the registrant, and preserves public confidence.

To facilitate a clearer approach to imposing sanctions, discipline panels and courts should focus on the degree of insight of the registrant.

This approach is not entirely foreign to Canadian courts. Recalling *Massiah v Justices of the Peace Review Council*, 2016

ONSC 6191 (CanLII), the Court's statement is consistent with that of the UK Court in *Higgins*. The Ontario Court said:

> … the 2012 Panel did not punish the applicant for contesting the allegations. Rather, having concluded that the misconduct had occurred, it found that the applicant did not have insight into his misconduct and, therefore, the 2012 Panel could not have any faith that the misconduct would not be repeated.

A principled analysis of the degree of insight requires consideration of how the registrant has discerned the issues before, during and after the hearing. Surely this can be done without creating the impression that the registrant is being "punished" for disputing the allegations or the panel venturing into a dizzying and technical debate about aggravating and mitigating factors. For all these reasons, we propose that regulators begin assessing a registrant's degree of insight when considering what sanction is appropriate in the professional regulation context.

This article was originally published by Law360 Canada, part of LexisNexis Canada Inc.

FOR MORE INFORMATION

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WANT TO REPRINT AN ARTICLE?

A number of readers have asked to reprint articles in their own newsletters. Our policy is that readers may reprint an article as long as credit is given to both the newsletter and the firm. Please send us a copy of the issue of the newsletter which contains a reprint from Grey Areas.

From Julie Maciura

In This Issue

Ontario Bills

(www.ola.org)

The Legislative Assembly is in recess.

Proclamations

(www.ontario.ca/search/ontario-gazette)

There were no relevant proclamations.

Regulations

(https://www.ontario.ca/laws Source Law - Regulations as Filed)

There were no relevant regulations posted.

Proposed Regulations Registry

(www.ontariocanada.com/registry/)

Expanded Scope of Practice for Nurses – A general consultation on this topic is described (in part) as follows:

> The Ministry of Health (MOH) is seeking feedback from the public and other system partners on whether potential expansions to the scopes of practice of NPs and RNs would support more timely delivery of health care. Those potential expansions to the scopes of practice of NPs and RNs fall into two areas:
>
> 1. Ordering and Applying Electricity:
>
> - Allowing NPs to order and apply electricity to treat heart conditions using defibrillation (without any limitations) and for transcutaneous cardiac pacing.
> - Allowing NPs to order electricity for the purposes of cardiac pacemaker therapy to treat heart conditions.
> - Allowing NPs to order and apply electricity for electrocoagulation.

2. Completing and Signing the Mandatory Blood Testing Forms:
    - Allowing NPs to complete and sign the mandatory blood testing forms for an applicant that needs to apply to have the blood of another person tested for specific infectious diseases if they have come into contact with their bodily fluids.

The MOH and Ministry of Public and Business Service Delivery (MPBSD) are also seeking feedback on:

- Amending the General regulation under the *Vital Statistics Act* to remove the limiting circumstances when NPs can certify death. Those limiting circumstances are where:
    - The nurse had primary responsibility for the care of the deceased during the last illness of the deceased;
    - The death was expected during the last illness of the deceased;
    - There was a documented medical diagnosis of a terminal disease for the deceased made by a legally qualified medical practitioner during the last illness of the deceased;
    - There was a predictable pattern of decline for the deceased during the last illness of the deceased; and
    - There were no unexpected events or unexpected complications during the last illness of the deceased.

- Amending the General regulation under the *Vital Statistics Act* to authorize RNs to, immediately after the death, complete and sign a Medical Certificate of Death if:
    - The RN had an established nurse-patient relationship with the deceased during the last illness of the deceased;
    - The death was expected during the last illness of the deceased;
    - There was a documented medical diagnosis of a terminal disease for the deceased made by a legally qualified medical practitioner or a registered nurse who holds an extended certificate of registration under the *Nursing Act, 1991*, during the last illness of the deceased;
    - There was a predictable pattern of decline for the deceased during the last illness of the deceased;
    - There were no unexpected events or unexpected complications during the last illness of the deceased; and
    - The death did not result from medical assistance in dying within the meaning of section 241.1 of the Criminal Code (Canada).

Comments are due by October 25, 2024.

Expanded Scope of Practice for Pharmacists and Pharmacy Technicians – A general consultation on this topic is described (in part) as follows:

To build on this success, the Ministry is consulting on additional minor ailments and further scope expansions to better meet the needs of patients in Ontario. The Ministry is seeking feedback on

whether these potential expansions to the scope of practice for pharmacists would improve access to more timely, safe, and competent care with a more connected and convenient health care experience.

The Ministry is also seeking feedback on the implementation of additional vaccine services in community pharmacies for adults and improving the MedsCheck program.

1. Scope of Practice Expansions

In January 2023, the Ministry launched the pharmacist minor ailment program. Minor ailments are health conditions that are typically short-term and can be managed with minimal treatment and/or self-care strategies. Currently, pharmacists can assess and prescribe for 19 minor ailments. As the program's list of minor ailments continues to grow, other scope expansions may be needed to support safe and accurate assessment and prescribing by pharmacists.

The Ministry is consulting on several changes to the scope of practice for pharmacists and is looking for feedback on:

- Adding more minor ailments to the program. This will also include the drugs and any limitations or conditions on those drugs from which pharmacists (Part A) may prescribe;
- Allowing pharmacists to order certain laboratory tests and to perform more point-of-care tests (POCTs) to support the minor ailments program;
- Allowing pharmacists to communicate a diagnosis for specific minor ailments; and
- The barriers that limit pharmacists from ordering laboratory and POCTs in hospital settings.

1.1 Prescribing for Additional Minor Ailments:

- The Ministry is consulting on adding more minor ailments to the program including:
    - Acute pharyngitis (sore throat), calluses and corns, headache (mild), shingles, minor sleep disorders (insomnia, could also include disturbances in circadian rhythm), fungal nail infections, swimmers' ear, head lice, nasal congestion, dandruff, ringworm, jock itch, warts, and dry eye.

1.2 Ordering Specific Laboratory and Performing Additional POCTs:

- Some of the newly proposed minor ailments may require additional laboratory and POCTs to better support the assessment, management, and treatment of these conditions.
- The Ministry is seeking feedback to determine whether laboratory tests and POCTs are required and if so, which ones would be best suited to support pharmacist assessment and prescribing.

1.3 Communicating a Diagnosis for Specific Minor Ailments:

- As the minor ailment program grows pharmacists may need to communicate a diagnosis.
- The Ministry is seeking feedback to determine whether communicating a diagnosis is required to support pharmacist assessment and prescribing.

1.4 Identifying Barriers in Hospital Settings

The *Public Hospitals Act, 1990 (PHA)* establishes a scheme for the appointment of physicians to a hospital's medical staff that grants them privileges to use hospital resources. Regulations under the *PHA* allow hospital boards to pass by-laws for the appointment of dentists, midwives, and registered nurses in the extended class. The *PHA* only allows physicians, dentists, midwives, and registered nurses in the extended class to issue orders for treatments or diagnostic procedures of a patient in a public hospital. The Ministry is exploring if there are barriers outside of the *PHA* that are preventing pharmacists from working to their full scope of practice in a hospital setting, including the ordering of laboratory and point-of-care tests.

The Ministry is seeking feedback on the barriers in hospital settings, other than legislative amendments, that limit hospital pharmacists from ordering laboratory and POCTs.

2. Vaccines in Community Pharmacies

The Ministry is looking for feedback on the implementation of two vaccine-related initiatives in community pharmacies, listed below.

2.1 Pharmacy Technicians Administering Additional Schedule 3 Vaccines

- Currently, pharmacy technicians are allowed to administer COVID-19, influenza, and RSV vaccines.
- The Ministry is expanding the vaccines pharmacy technicians can administer to include those listed under Schedule 3 of the General regulation made under the *Pharmacy Act, 1991.*
- This includes certain travel and other vaccines:
    - Bacillus Calmette-Guérin (BCG) Vaccines
    - Haemophilus Influenzae type b (Hib) Vaccines
    - Meningococcal Vaccines
    - Pneumococcal Vaccines
    - Typhoid Vaccines
    - Combined Typhoid and Hepatitis A Vaccines
    - Hepatitis A Vaccines
    - Hepatitis B Vaccines
    - Hepatitis A and B combined Vaccines
    - Herpes Zoster Vaccines
    - Human Papillomavirus (HPV) Vaccines
    - Japanese Encephalitis Vaccines
    - Rabies Vaccines
    - Varicella Vaccines
    - Yellow Fever Vaccines
    - Respiratory Syncytial Virus (RSV) Vaccines
    - Influenza Vaccines
    - Coronavirus (COVID-19) Vaccines

- Patients who choose to receive vaccines in a community pharmacy will need to pay for the vaccine and the administration. Patients will not have to pay any fees for COVID-19 and influenza vaccines.
- This proposed change would require the College to amend O.Reg 202/94 under the *Pharmacy Act, 1991*. This would need to be approved by the College's Council prior to bringing it forward for the Minister's review and the Lieutenant Governor in Council's approval.

2.2. Adult Vaccine Bundle

- The Ministry is implementing a publicly funded adult vaccine bundle and is seeking additional feedback to shape the implementation of this initiative.
- This includes the development of clinical guidance, education and training, inventory and documentation protocols and guidance.
- It is being proposed that the publicly funded vaccines for adults available in community pharmacies will include tetanus, diphtheria, pertussis, pneumococcal, shingles, and RSV (potentially based on eligibility for publicly funded programming).

3. MedsCheck

MedsCheck is a one-on-one consultation between a pharmacist and a patient to review the patient's medication profile, provide education, resolve drug therapy problems, and improve medication adherence and patient clinical outcomes. Current MedsCheck eligibility criteria include patients taking three or more chronic-use prescription medications, or those diagnosed with type 1 or 2 diabetes.

The Ministry is committed to supporting an effective and sustainable MedsCheck program that supports both patients and health care providers. As part of this, the Ministry is exploring opportunities to improve the program.

Comments are due by October 20, 2024.

Fixing Long-Term Care Act, 2021 – Proposed regulations would set out when unregistered personal support workers can work in a long-term care home. It also proposes circumstances in which a registered dietitian would not have to be onsite. Comments are due by October 11, 2024.

Bonus Features

These include some of the items that appear in our blog:
(www.sml-law.com/blog-regulation-pro/)

Direct Democracy and Professional Regulation

The ability of registrants to pass motions at a general meeting or otherwise offer guidance to their regulatory bodies is again in the news. The resulting controversy raises the question about the role of registrants in suggesting priorities to their regulator.

Law professor Amy Salyzyn has published a blog on the issue: Bad Ballots: Down With Direct Democracy in Law Society Governance. Salyzyn's thesis is that "direct democracy" is inappropriate for regulators:

> … direct democracy processes clash with the mandate of law societies. Law societies exist to serve the public interest. Given this reality, it is inappropriate to have mechanisms allowing lawyers to centre their own interests on the regulatory agenda or for law societies to seek out lawyer preferences via direct voting on referenda.

Further, such processes can "harm public confidence in the … profession and its regulation." The initiatives often deal with the self-interest of the profession.

The very existence of some mechanisms creates the impression that members of the profession, rather than the public, are the "owners" of the regulator. This perception is reinforced by the fact that members of the general public do not have a means of advancing resolutions at meetings.

Salyzyn concludes:

> Finally, direct democracy processes can also impose significant costs on the legal community. In the most high-profile cases, law societies and legal organizations find themselves needing to divert energy and resources from their usual work in order to respond publicly. In the most divisive cases, ideologically driven measures advanced by individual lawyers or small groups of lawyers can amplify conflict within the legal profession. These are not abstract intellectual exercises without real-world consequences.
>
> It is a good thing for lawyers to be interested in legal services regulation. It is also good for law societies to consider lawyer perspectives when regulating. But lawyer-initiated resolutions and law society referenda are not good vehicles for either of these things. They conflict with law society public interest mandates, risk hurting public confidence in the legal profession, and can drain resources and strain collegiality within the profession. In jurisdictions where they are available, direct democracy processes should be abolished.

The new *Legal Professions Act* in British Columbia, if proclaimed, will eliminate the ability of registrants to pass resolutions.

Complaints Against Investigators

Complaints are sometimes made against those involved in regulatory investigations about how they conducted the investigations. Those complaints are often dismissed. Courts say there is a high hurdle before they will intervene.

> In its decision, the Complaints Director noted that the law is settled that police officers are entitled to use their discretion in the course of their duties. This exercise of discretion extends to their investigations and their decisions regarding the arrest of suspects and/or the laying of charges. Provided they act in good faith and within the bounds of reasonableness, an officer's legitimate exercise of discretion cannot be considered misconduct ….

While this case is about a complaint about the conduct of a police officer, a similar approach may be taken for complaints against other investigators / screeners as well. See: 2024 ONSC 5266 (CanLII) | Liu v. London Police Service | CanLII.

Another Exception to the Open Court Principle

The Licence Appeal Tribunal identified potentially disturbing details about funeral and similar arrangements that warranted a limited exception to the usual rule that evidence and exhibits at hearings be publicly accessible. The Tribunal said:

> I note that the Supreme Court in *Sherman Estate* recognised that preservation of an individual's dignity is a matter of public interest. I find that there is an important public interest to protecting the particulars of the embalming, cremation and burial of the deceased individuals. I note that some of the details regarding the state of the decomposing bodies of the deceased is intimate and sensitive information that could cause harm to the loved ones of the deceased persons. A confidentiality order is appropriate to protect a family's privacy and spare them any further distress. I further find that the order is necessary to prevent the serious risk to the identified interest because there are no practical alternatives that will address the identified risk. Lastly, I find that as a matter of proportionality, the benefits of the order outweigh its negative effects as I will limit the scope of the confidentiality order to anonymizing the names of the deceased persons and specific and limited portions of the record.
>
> I conclude that having regard to the circumstances of this case and the sensitive evidence, the desirability of limiting public access to a discrete part of the evidentiary record outweighs the desirability of adhering to the principle that the documents be open to the public.

See: *Luann M.H. Jones and Covenant Funeral Homes Inc. v Registrar, Funeral, Burial and Cremation Services Act, 2024* CanLII 88892 (ON LAT).

Regulator Engages Employers to Address Sexual Abuse

The UK regulator for physicians has issued guidance to employers and supervisors of registrants about preventing and dealing with allegations of sexual abuse. For example, the document states:

> "Taking a firm and consistent stand on issues of sexual misconduct is also an important part of ROs' [supervisor's] fitness to practise role. To ensure that potential harm to patients and colleagues is minimised, it is important that you identify any concern about a doctor's practice as early as possible and take appropriate and timely action where necessary. This is especially important as serious sexual misconduct, including rape, is usually preceded by a period of inappropriate comments or touching. Instances of sexual misconduct are also seldom isolated; perpetrators often offend repeatedly, and some abuse can last several years. Taking swift and early action can help prevent the misconduct from escalating. It can also help avoid this behaviour from developing into victimisation, bullying, and exclusion of the victims/survivors from the team in which they work, all of which have significant impacts on individuals and can also impact negatively on patient safety and team cultures."

It's All in How You Say It

Most public interest boards of directors have a Code of Conduct designed to facilitate the effectiveness of the board, protect staff from inappropriate conduct, and preserve the reputation of the organization. One such Code of Conduct was tested at the Ottawa Carlton District School Board in *Kaplan-Myrth v. Ottawa Carlton District School Board*, 2024 ONSC 4280 (CanLII).

A complaint was made that an elected Trustee "was rude, insulting, intimidating and disrespectful" to the board, other board members, and staff members. In public statements including her personal social media account, she called the board a "kangaroo court", said that other Trustees had "been out to get me from day one", called a fellow Trustee an "idiot", failed to follow meeting protocols, and alleged bad faith by staff, among other things. After an investigation by the organization's Integrity Commissioner, the board found that she had breached several provisions of the Code of Conduct. The board suspended the Trustee for the next regular board meeting and from attending committee meetings for three months.

The Court upheld the finding and order. While the outcome infringed the Trustee's right to freedom of expression, the reasons given for doing so reflected a proportionate balancing of the various interests.

The Court also rejected the Trustee's argument that her "fiduciary obligation is to the electors and to the children of the district and there is no obligation on a trustee to abstain from criticism of the Board or its processes." Citing another case, the Court said:

> … it was reasonable for the respondent board in that case to sanction the applicant trustee for criticizing the board and its processes, including on the trustee's personal social media accounts. In so holding, this court found that the board's code of conduct was designed to maintain "the

> integrity and dignity of [the Applicant's] office, civil behaviour, compliance with legislation and upholding of decisions of the board."

What was objectionable was not so much the strongly held views of the Trustee but the manner in which she expressed those views.

The Court also found that there was no procedural unfairness in the process the board followed. Even though the applicable provisions did not permit the Trustee to make oral presentations before the board rendered their final decision, she had ample opportunity to present her position throughout the process.

It really is all in how you say it.

From Julie Maciura

In This Issue

Ontario Bills

(www.ola.org)

Bill 190, Working for Workers Five Act, 2024 – (*Government Bill – passed third reading and received Royal Assent*) Bill 190 amends a number of statutes, including the *Fair Access to Regulated Professions and Compulsory Trades Act, 2006,* to add new sections requiring regulated professions to have policies respecting the accepted alternatives to the usual documentation of qualifications and to have plans addressing how they will enable multiple registration processes to take place concurrently. There are also requirements respecting the contents of policies and plans. In addition, the *Employment Standards Act* would be amended to "[p]rohibit an employer from requiring an employee to provide a sick note from a qualified health practitioner to show evidence of entitlement to ESA's sick leave. Employers would retain the ability to require evidence reasonable in the circumstances, but not a sick note from a qualified health practitioner."

Bill 194, Strengthening Cyber Security and Building Trust in the Public Sector Act, 2024 - (*Government Bill – passed second reading, referred to Standing Committee on Justice Policy*) Bill 194 sets out a framework for regulating the use of artificial intelligence (AI) by the public sector. The details will depend on the regulations which are still to be developed. However, the rules will likely involve disclosure to the public of how AI is being used by the public sector organization (and its third-party suppliers), security measures, perhaps some limits on the use of AI for certain purposes, and the need for an actual individual to oversee the use of AI. While this Bill will not directly affect *RHPA* colleges because neither the *Freedom of Information and Protection of Privacy Act* nor the *Municipal Freedom of Information and Protection of Privacy Act* applies to them (and those are the "public institutions" impacted by the Bill), it may be a forerunner of future legislation that will.

Proclamations

(www.ontario.ca/search/ontario-gazette)

There were no relevant proclamations.

Regulations

(https://www.ontario.ca/laws Source Law - Regulations as Filed)

Ontario College of Teachers Act – The regulation requires successful completion of the mathematics proficiency test, provides for the suspension of teacher's certificates for those who have not successfully completed the sexual abuse prevention program, and revises some of the other registration requirements. (O. Reg. 402/24)

Proposed Regulations Registry

(www.ontariocanada.com/registry/)

Homeopathy Act, 2007 and Opticianry Act, 1991 – Both Colleges propose a regulation permitting a spousal exception to the sexual abuse provisions for their registrants. Comments are due by December 6, 2024.

Psychotherapy Act, 2007 – The College proposes a regulation extending the definition of patient, for the purpose of the sexual abuse provisions, to five years after cessation of care. Comments are due by December 6, 2024.

Respiratory Therapy Act, 1991 – The College proposes to amend its registration regulation, primarily relating to its currency requirements. Comments are due by November 3, 2024.

Ministry of Training, Colleges and Universities Act – "The Ministry of Colleges and Universities is proposing legislative amendments to the *Ministry of Training, Colleges and Universities Act* (*MTCU Act*) to require all publicly-assisted Ontario universities to reserve a minimum of 95 per cent of their annual medical school admissions for Ontario students and to reserve the remaining 5 per cent for Canadians, permanent residents, protected persons, or prescribed persons or classes or persons." Comments are due by November 28, 2024.

Bonus Features

These include some of the items that appear in our blog:
(www.sml-law.com/blog-regulation-pro/)

Stay in Your Lane?

The Alberta government announced a consultation on whether the scope of professional regulation should be restricted to professional conduct and behaviour such that freedom of expression is not affected. The announcement says, in part:

> In response to increasing concerns that regulated professional bodies may be going too far in limiting individual freedom of expression and imposing compulsory training beyond the scope of their professional practice, Alberta's government is launching an engagement this fall that will include hearing directly from affected members.
>
> As part of the province's commitment to protecting the civil liberties of all Albertans, the government is considering legislative changes to clarify that professional regulatory bodies are limited to regulating members' professional competence and behaviour. The engagement will ensure that professional regulatory bodies uphold the rights and freedoms of their members, and that Albertans can share their experiences and opinions.

> The review will be informed by input from professional regulatory bodies, regulated professionals and other organizations, associations or experts. These groups will be invited to share their views on whether regulatory oversight goes beyond professional competence and ethics in areas such as freedom of expression and opinion, training not related to professional competence, vexatious and bad faith complaints, third-party complaints and protection for those holding other roles in addition to their role as a regulated professional.

See: Protecting Albertans' rights and freedoms | alberta.ca.

Feedback Loop

Courts are much higher on the decision-making "ladder" than are administrative tribunals. Courts can reverse tribunal decisions and issue directions for them to follow. Court decisions dealing with one tribunal can also be binding precedents for another tribunal. However, that is not to say that tribunals can never guide the courts. This feedback loop is illustrated in *Oladipo v The College of Physicians and Surgeons of Saskatchewan*, 2024 SKCA 94 (CanLII).

An emergency room physician was disciplined for discreditable conduct for his interactions with nurses at the facility. It was alleged that the physician had kissed and attempted to tickle nurses.

As an example of a court directing a tribunal, the Court set aside the finding of misconduct on the basis that the tribunal had not effectively dealt with the credibility issues in the evidence of one of the regulator's key witnesses. The tribunal had not adequately analyzed the inconsistencies in the witness' evidence and prior statements. The tribunal had also not addressed a concern about the reliability of the witness' testimony when it found that another incident (conduct towards a ward clerk), about which the witness testified, had not been proved. A new discipline hearing was required to address the credibility issues (as it was not for the court to make a credibility decision based on a transcript).

The Court also engaged in a detailed discussion of whether the kissing and tickling incidents were sexual in nature. The Court was of the view that the tribunal gave inadequate reasons for its conclusion that the conduct was inherently sexual in nature. In doing so, the Court relied upon a tribunal level decision in *(College of Physicians and Surgeons) v Shamess*, 2019 ONCPSD 22 at 41–42, where the discipline committee said:

> The determination of whether an act is of a sexual nature is an objective test. The subjective beliefs of the complainants, although important and to be taken into consideration, are not determinative of the issue. Similarly, the subjective intent of the physician is not determinative but simply one of many factors in deciding if the conduct is sexual in nature. Many aspects of the alleged misconduct will be considered in deciding whether the actions of the doctor were of a sexual nature including, as stated in *R. v. Chase*:
>
> a) The part of the body touched,
> b) The nature of the contact,

c) The situation in which it occurred,
d) Any words or gestures accompanying the act,
e) All other circumstances surrounding the conduct, including threats which may or may not be accompanied by force,
f) The intent or purpose of the person committing the act and,
g) Whether the motive of the accused is sexual gratification.

Another point of discussion might be worthy of further input into the feedback loop. The Court felt that there should have been evidence for the tribunal's view that there was a power imbalance between physicians and nurses, although the Court said it would not have reversed the decision for that error alone. Since this is an ethical issue, rather than a standards of practice issue. one might question whether the tribunal's expertise might be sufficient to support such a view.

This decision illustrates that tribunals and courts are often engaged in a subtle form of ongoing dialogue.

Procedural Fairness Towards the Tribunal

In a discipline hearing, procedural fairness is intended to ensure that the registrant knows the concerns against them and has a full opportunity to respond to them. However, the registrant also has some obligation to be fair to the tribunal. For example, it is unfair for a registrant to agree to a procedure (or, at least, not object to it) and then argue on appeal that the tribunal should have acted otherwise. This theme recurs frequently in *Llewellyn v. College of Registered Nurses and Midwives of P.E.I.*, 2024 PESC 41 (CanLII).

A nurse was found to have breached standards of practice and engaged in professional misconduct by engaging in threatening and inappropriate behavior towards a facility resident. The resident had earlier been aggressive towards the nurse (including bruising her legs with his walker). The Court upheld the finding and the sanction (which included a four-month suspension and terms and conditions). In responding to several grounds of appeal, the Court made the following points.

- The nurse could not argue on appeal that the discipline panel acted beyond the scope of the notice of hearing where the nurse fully responded (including with evidence and argument) to the full course of events without objection. It was appropriate in the circumstances for the panel to address the entire series of transactions on the relevant date and not just the main incident with the resident.
- The nurse could not argue on appeal that the panel should not have relied on hearsay evidence contained in a joint book of documents without raising the issue at the hearing. In any event, less formal rules of evidence were permitted under the relevant statute.
- The nurse could not argue on appeal that the panel should have provided reasons for its finding of misconduct before seeking submissions on sanction when that process had been discussed at the start of the hearing and the nurse made submissions on sanction without objection after the finding was made.
- The statutory obligation to provide reasons for decision within 60 days of the end of the hearing was not mandatory. There were no consequences specified in the statute for missing the deadline. The reasons were only a month late and an explanation was offered for the delay. "The Courts

have found that where a discipline committee is performing a public duty, rather than resolving a dispute between two private individuals, the complainant, the public and the profession would all suffer injustice and inconvenience if the provision was regarded as mandatory."

- While the reasons for the panel's decision were not what a Court might have written, it was evident from their reasons that the panel did not conclude that every breach of standards always constitutes professional misconduct.
- The sanction did not contain an error in principle. It was appropriate for the panel to consider the prior finding against the nurse, including the failure to fulfil the previously ordered conditions. (Note that no stay of the sanction was sought during the nurse's appeal of the previous order.) It was also appropriate for the panel to give less weight to unsigned letters of support where it was not clear what the authors knew about the nurse's conduct history or the current findings.

Courts seem to be increasingly resistant to issues being raised for the first time on appeal.

Social Media Use by Decision-Makers

Much guidance has been given by regulators on the use of social media by registrants. For example, the Royal College of Dental Surgeons of Ontario recently updated its detailed guidelines. However, less guidance is often given to Board and committee members of regulators (although many regulators encourage responsible social media use in their governance documents).

The Canadian Judicial Council recently updated its guidelines for the safe and appropriate use of social media by judges. These guidelines may be instructive for Board and committee members of regulators, particularly those with adjudicative roles. Highlights include the following:

- Judges "can use social media but need to do so cautiously and with a view to their ethical obligations. Improper social media use can undermine the principles of independence, integrity and respect, diligence and competence, equality and impartiality that define the judicial role, as well as public confidence in the judiciary."
- Judges should review their social media use upon their appointment including the appropriateness of the platform and their connections.
- "Using [pseudonyms] is neither recommended nor prohibited. However, a judge should be aware that taking such means will not preclude third parties from identifying the person with a particular social media account. Moreover, taking steps to shield one's identity does not justify or excuse otherwise improper social media behaviour. In some cases, identity-shielding measures can give rise to other ethical concerns."
- The explicit use of the person's title and role on platforms is discouraged. Others may view the communications as being directly associated with the judge's work or organization.
- "A judge should not use social media to conduct independent factual research about a case that is before them."
- "If, in using social media, a judge inadvertently acquires or receives out-of-court information related to the parties, witnesses, or issues under consideration in matters before them, fairness issues may need to be considered by the judge."

- Judges should not express their personal opinions about matters that may come before them. However, social media can be used to engage in educational activities that may benefit the public.
- "When creating or interacting with social media content, a judge should be mindful of their ethical responsibilities to treat others with civility and respect and avoid partisan activity. Social media behaviours that might be considered acceptable for a member of the general public may not be appropriate for members of the judiciary."
- "If a judge is subjected to harassing, derogatory, defamatory, or otherwise abusive comments on social media, they must refrain from responding directly to the comments and should instead refer the matter to …" the appropriate person or institution.
- "Judges should be particularly careful about virtual connections with parties, counsel or witnesses in cases before them, which may raise perceptions of partiality, and require corrective measures. A judge should avoid associating online with individuals or organizations that engage in or countenance discrimination contrary to the law."
- "A judge should take reasonable efforts to monitor their social media accounts…. A judge should be attentive to and may wish to inform family members and friends of the ways in which their social media activities could reflect adversely on the judge…."
- "A judge should be mindful that, regardless of the privacy settings they enable, their account or any content associated with their account could still become public. For example, it is possible that someone a judge has permitted to view their social media account may share content beyond the judge's approved network without first seeking the judge's consent. Accounts can also be "hacked" by malicious actors who may be able to subvert privacy and security protections."

While individuals acting as adjudicators in regulatory contexts would probably not be held to a standard quite as high as that for judges (especially if they are members of the profession commenting on general professional issues), these guidelines are helpful. In addition, individuals acting in non-adjudicative capacities (e.g., as a board member) can also find much guidance from this document.

Postpone for Parallel Proceedings?

Should a regulator postpone its investigations where the registrant is involved in a parallel proceeding addressing many of the same issues? In *Bauhuis v Association of Professional Engineers and Geoscientists of Alberta*, 2024 ABKB 603 (CanLII), an Alberta court upheld a regulator's decision to proceed.

The regulator for professional engineers was investigating concerns about a pipeline failure. The now-retired professional engineer and his former employer declined to answer questions or provide documents, asking that the investigation be postponed until the parallel civil proceedings were completed. The regulator declined to adjourn its processes giving detailed reasons, and the engineer then initiated court proceedings.

The Court upheld the regulator's refusal to postpone the investigation, making the following points:

- The possible prejudice to those involved in the civil proceedings was not the only consideration.
- The risk to the public from an extensive delay (the investigation was now eight years old) was only part of the concern. As the regulator said "… the public interest in continuing the investigation

goes beyond him as an individual member, and that if it were to go to a discipline hearing, the principles of education and general deterrence for the larger membership would play an important role."

- More delay risked the loss of relevant evidence and the further fading of memories.
- Unlike many other regulatory statutes, the outcome of the discipline process was potentially admissible evidence in the civil proceeding. However, the participants in the civil process could give no weight to those findings or limited weight.
- The Court said: "… there is a strong public interest in ensuring that statutory bodies are permitted to fulfill their mandate. This is particularly the case when dealing with issues of disciplinary matters of self-regulating professions …."
- Regulatory proceedings and court proceedings were separate and distinct spheres and caution should be taken before one is permitted to dominate the other.

The Court found that the analysis by the regulator reasonably balanced the competing considerations.

The Court also found that there was no procedural unfairness on the part of the regulator. The regulator did not create a legitimate expectation that the engineer could defer his response until they had access to documents from the former employer. An earlier preference by the regulator to proceed in that manner did not prevent it from requiring a response when the employer then refused to provide the documents.

Similarly, there was no appearance of bias created by the regulator proceeding with the investigation based on a report from the same entity that later sued some of the parties. The motivation of a complainant should not be imputed to the regulator. The information provided justified initiating the investigation.

The Court did decline to order the engineer and his former employer to provide the requested documents and answer questions. Under the legislative scheme, the remedy for the regulator was to discipline them for non-cooperation.

This decision dealt with parallel civil proceedings. While the type of prejudice might be different in criminal proceedings, a similar contextual analysis of the competing considerations by the regulator should be conducted.

In All the Circumstances

Clear and rigid rules are easiest to apply. For example, discipline panels would have an easier time if there was never a requirement to prove intent before making a finding of professional misconduct. It would also be easier if a registrant's mental condition was relevant only to sanction and not to whether a finding of professional misconduct should be made, or if a registrant could not rely upon the legal advice they received when defending their actions. However, strict rules are also inflexible and can be unfair. As a result, courts increasingly require regulators to apply a contextual analysis, an expectation illustrated by British Columbia's highest court in *Gregory v. The Law Society of British Columbia*, 2024 BCCA 350 (CanLII).

A lawyer was found to have engaged in professional misconduct for taking steps in court on behalf of a client who appeared to be using the lawyer to facilitate money laundering. The lawyer acknowledged that there were suspicious circumstances but argued that he was simply deferring his duty to make inquiries. The Court upheld the finding because the lawyer should not have advanced the litigation without first making those inquiries. For example, the lawyer filed an affidavit that, on cursory scrutiny, contained false information. The matter was returned to the regulator to assess the sanction that should be imposed.

The Court indicated that a contextual approach should be taken to determine whether the lawyer's omission amounted to a "marked departure from expected practice". Moral turpitude was not required. Some delay by the lawyer in making the necessary inquiries might be tolerated, but not where active steps were taken to advance the litigation as those steps could facilitate dishonesty and fraud. While the "marked departure" test was largely objective, some subjective elements (e.g., the lawyer's understanding of the facts) were part of the context. The Court found that, even applying the contextual approach, the lawyer's conduct was a "marked departure".

The Court also agreed that, generally, mental health issues were primarily relevant to sanction. However, the Court said: "While circumstances where mental health issues are critical at the facts and determination phase may be rare, there will be cases in which they weigh heavily at that stage." However, in this case the evidence did not establish that the lawyer was prevented to fulfill his professional obligations by their condition:

> While it is true that the appellant was having a great deal of difficulty focussing on the file, the evidence did not suggest that his mental difficulties rendered him incapable of making reasonable inquiries, yet capable of advancing the file. In the circumstances, his priority had to be in making the inquiries and receiving satisfactory responses.

Similarly, the Court indicated that a lawyer's reliance on legal advice can sometimes be considered in determining whether there was professional misconduct:

> Again, it is important to recognize that a hearing panel must consider all of the circumstances before reaching a conclusion as to whether a lawyer's practice falls markedly below professional norms. Particularly in the case of complex and specialized transactions, lawyers may have little choice but to rely on more specialized or experienced lawyers to guide them through parts of a transaction. It cannot be categorically stated that reliance on such advice will, in all cases, be a marked departure from acceptable practice, even if the underlying advice turns out to be quite wrong. The analogy to criminal and to quasi-criminal offences is incomplete, and, in my view, not particularly helpful.

However, in this case, there was no clear legal advice given to the lawyer that justified his continuing to advance the litigation without making the necessary inquiries.

Regulators should take a contextual approach when determining whether a registrant's conduct falls below generally accepted standards of practice or otherwise constitutes professional misconduct.

The College of Naturopaths of Ontario

Council Meeting Evaluation
September 2024
8 Evaluations Received

Topic	Question	Scoring	Rating
Were issues discussed essential?	Please rate how essential you feel the issues covered in today's meeting were using a scale: 1 - Not at all essential to 5 - Very Essential.	3@5 5@4	**4.4**
Achieve Objectives?	Please rate how well you feel the meeting met the intended objectives using the following scale: 1 - Not at all met to 5 - All objectives met.	7@5 1@4	**4.9**
Time Management	Please rate how well you feel our time was managed at this meeting using the following scale: 1 - Not at all managed to 5 - Very well managed.	7@5 1@3	**4.8**
Meeting Materials	Please rate how helpful you feel the meeting materials for today's meeting were using the following scale: 1 - Not at all helpful to 5 - Very helpful.	8@5	**5**
Right People	Please rate the degree to which you felt the right people were in attendance at today's meeting using the following scale: 1 - None of the right people were here to 5 - All of the right people were here.	5@5 3@4	**4.6**
Your Preparedness	Please rate how you feel your own level of preparedness was for today's meeting using the following scale: 1 - Not at all adequately prepared to 5 - More than adequately prepared.	4@5 3@4 1@3	**4.4**
Group Preparedness	Please rate how you feel the level of preparedness of your Council colleagues was for today's meeting using the following scale: 1 - Not at all adequately prepared to 5 - More than adequately prepared.	1@5 2@4 2@3	**4.5**
Interactions between Council members	Please rate how well you feel the interactions between Council members were facilitated using the following scale: 1 - Not well managed to 5 - Very well managed.	6@5 2@4	**4.8**
What worked well?	From the following list, please select the elements of today's meeting that worked well.		
	Meeting agenda		**8/8**
	Council member attendance		**7/8**
	Council member participation		**8/8**

	Facilitation (removal of barriers)	**8/8**
	Ability to have meaningful discussions	**8/8**
	Deliberations reflect the public interest	**8/8**
	Decisions reflect the public interest	**8/8**
Areas of Improvement	From the following list, please select the elements of today's meeting that need improvement.	
	Meeting agenda	**0/8**
	Council member attendance	**1/8**
	Council member participation	**0/8**
	Facilitation (removal of barriers)	**0/8**
	Ability to have meaningful discussions	**0/8**
	Deliberations reflect the public interest	**0/8**
	Decisions reflect the public interest	**0/8**
Things we should do	(None)	
Final Feedback	The governance quiz session once again felt like a needless exercise. I would appreciate if those sessions were shortened or eliminated, and the materials presented as a memo inside of the consent agenda.	
	Wonderful, productive, and informative Council Meeting. I so appreciate the effort that goes into the planning and delivery of these Council Meetings.	

Comparison of Evaluations by Meeting 2024-2025

	2023/24 Overall	**2024-2025**						
Topic		**May 2024**	**July 2024**	**Sept 2024**	**Nov 2024**	**Jan 2025**	**Mar 2025**	**Ave**
Were issues discussed essential? 1 – Not at all essential to 5 – Very Essential.	**4.6**	**4.2**	**4.4**	**4.4**				**4.3**
Achieve Objectives? 1 - Not at all met to 5 - All objectives met.	**4.8**	**5**	**5**	**4.9**				**5**
Time Management 1 - Not at all managed to 5 - Very well managed.	**4.5**	**4.2**	**4.6**	**4.8**				**4.5**
Meeting Materials 1 - Not at all helpful to 5 - Very helpful.	**4.8**	**4.7**	**5**	**5**				**4.9**
Right People 1 - None of the right people to 5 - All of the right people.	**4.8**	**4.8**	**4.8**	**4.6**				**4.7**
Your Preparedness 1 - Not at all adequately prepared to 5 - More than adequately prepared.	**4.5**	**4.2**	**4**	**4.4**				**4.2**

Group Preparedness 1 - Not at all adequate 5 - More than adequate.	**4.3**	**4.5**	**3.8**	**4.5**				**4.3**
Interactions between Council members 1 - Not well managed to 5 - Very well managed.	**4.7**	**4.5**	**5**	**4.8**				**4.8**
Number of Evaluations	**7.3**	**10**	**5**	**8**				**7.7**

Health practitioner regulation

Design, reform and implementation guidance

World Health Organization

Health practitioner regulation

Design, reform and implementation guidance

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Health practitioner regulation: design, reform and implementation guidance

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Contents

Preface

World Health Organization's (WHO) Global Strategy on Human Resources for Health, adopted by the World Health Assembly in 2016, set out a clear vision and goal to accelerate progress towards universal health coverage and the health-related Sustainable Development Goals by 2030, including the call for effective public policy stewardship, leadership and governance.

Regulatory frameworks and appropriate regulation of health professionals were identified as critical elements of this stewardship agenda; with huge potential to promote broader health system goals, health systems strengthening and efficiency alongside the traditional roles of patient safety and ethical standards. In adopting the Global Strategy, Member States called upon regulatory bodies to engage in this agenda and contribute towards ensuring the education, employment, retention and enhanced performance of multi-disciplinary teams that would be responsive to population health needs.

This guidance on health practitioner regulation is rooted in the Health Assembly's 2016 request and builds upon the outcomes of the Global Symposium on Health Workforce Accreditation and Regulation held in Istanbul, Türkiye in December 2019. The guidance aims to support countries strengthen health practitioner regulatory systems in alignment with national health system priorities, tackling both regulatory gaps and policy options to inform the design, implementation, and reform of health practitioner regulation.

Appreciation is extended to the group of international academics, researchers and regulators that have enabled the development, review and completion of this first global guidance on health practitioner regulation published by WHO.

Having consolidated the international evidence, WHO looks forward to operationalizing the guidance with policy makers, regulators, health professions, civil society and employers in the context of national health practitioner regulatory systems, accompanied by robust implementation of workforce research and science. Through these processes, the anticipated potential of health practitioners' regulation on broader policy goals and population health outcomes can be realized.

Jim Campbell
Director, Health Workforce Department
World Health Organization

Acknowledgments

The World Health Organization (WHO) would like to thank the many individuals who contributed to the development of this document. This document was prepared by Agya Mahat, Giorgio Cometto and Ibadat Dhillon, who led the conceptualization and coordination of the guidance development process, under the oversight of James Campbell (Health Workforce Department). The Health Workforce Department is part of the Universal Health Coverage and Health System Cluster in WHO.

The WHO Secretariat identified members of the Technical Expert Group on health practitioner regulation, facilitated its meetings, and led the drafting of this guidance. Other WHO Secretariat staff members included:

Adam Ahmat (WHO Regional Office for Africa); Gulin Gedik Fethye (WHO Regional Office for the Eastern Mediterranean); Jose Garcia Gutierrez (Pan American Health Organization); Masahiro Zakoji (WHO Regional Office for the Western Pacific); and Tomas Zapata (WHO Regional Office for Europe). Onyema Ajuebor, Mathieu Boniol, Laurence Codija, Khassoum Diallo, Siobhan Fitzpatrick, Rania Kawar, Carey McCarthy, Michelle McIsaac, Tapas Sadasivan Nair, Amani Siyam and Huan Xu (WHO headquarters) provided inputs to subsequent drafts of the guidance. Li Yachan (WHO Traditional Complementary and Integrative Medicine Unit) reviewed the draft guidance for relevance to the practitioners of traditional, complementary and integrative medicine.

The Technical Expert Group refined the scope of the guidance, contributed to the evidence and policy considerations, and reviewed the drafts. The members included: Elsheikh Badr (formerly of the Sudan Medical Specialization Board, Sudan); Ruth Nigatu Belachew (Ministry of Health, Ethiopia); David Benton (National Council of State Boards of Nursing, the United States of America); Antonia Carzaniga (World Trade Organization); Jishnu Das (Center for Policy Research, India and Georgetown University, the United States); Mark Dexter (General Medical Council, the United Kingdom of Great Britain and Northern Ireland); Martin Fletcher (Australian Health Practitioner Regulation Agency, Australia); André Gariépy (Office des professions, Québec, Canada); Morris Kleiner (University of Minnesota, the United States); Elizabeth Oywer (Kenya); Michele Rumsey (University of Technology Sydney, Australia); Mike Saks (University of Suffolk, the United Kingdom); Natewinde Sawadogo (World Bank Centre of Excellence for Studies, Training and Research in Social Risks Management, Burkina Faso); Joan Simeon (Medical Council of New Zealand, New Zealand); Andre Verani (Centers for Disease Control and Prevention, the United States); and Francis Wafula (Strathmore University, Kenya). Joscelyn Magdeleine (World Trade Organization) provided technical inputs.

This guidance has benefited from a careful review and insights by Harry Cayton (Professional Regulation and Governance, the United Kingdom).

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Declarations of interest were collected from the Technical Expert Group members and managed according to WHO policy. No conflict of interest was identified that required action.

Abbreviations and acronyms

CPD	Continuing professional development
HIC	High-income country
LMIC	Low- and middle-income country
NLE	National licensing exam
TCIM	Traditional, complementary and integrative medicine
TEG	Technical Expert Group
WHO	World Health Organization

Glossary

Accreditation: In a health workforce context, the evaluation of educational institutions and programmes of study against pre-defined standards required for the delivery of education. The outcome of the process is certification of the suitability of education programmes, and the capability of educational institutions to deliver initial and/or continuing education.

Competence: The state of a person's proficiency to perform the required work activities to the defined standard. This includes having the requisite competencies in each context. Competence is multidimensional, dynamic and changes with time, experience and setting – adapted from *(1)*.

Complementary medicine: 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 system *(2)*.

Cultural safety: Recognition of the impact of multiple cultural domains on clinical interaction and health service delivery and the commitment to address any of the biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided – adapted from *(3)*.

Dual practice: Phenomenon in which a health practitioner is simultaneously employed or holds dual or multiple appointments (in both the public and private sectors) in regulated as well as unregulated ways and in an authorized or informal manner.

Harm: Harm is the impairment of structure or function of the body and/or any deleterious effect arising therefrom. Harm includes disease, injury, suffering, disability and death. This includes any negative consequences for an individual's mental and or social well-being – adapted from *(4)*.

Health associate professional: Health personnel (including facility-based and community health workers) who perform technical and practical tasks to support the diagnosis and treatment of illness, disease, injuries and impairments, and to support the implementation and provision of health services treatment and referral plans, etc. – adapted from *(5)*.

Health practitioner: For the purpose of this document, the term "health practitioner" encompasses all health professionals, health associate professionals, including community health workers, health care assistants, and personal care workers in health services (allopathy as well as traditional, complementary and integrative medicine) as defined in the International Standard Classification of Occupations (ISCO-08), and new or health practitioners that are yet to fall under an official classification but who are directly involved in patient diagnostics or care.

Health professional: Health personnel who apply knowledge, such as those relating to medicine, nursing, midwifery, dentistry, and allied health and health promotion; they usually require a university undergraduate or postgraduate degree or the equivalent – adapted from *(5)*.

Occupation: A set of jobs with main tasks and duties that are characterized by a high degree of similarity *(6)*.

Outcome of regulation: The results that regulation is designed to achieve (for example, to protect the public, facilitate the efficient and effective movement of registrants from one jurisdiction to another, and the alignment of practice with contemporary needs) – adapted from *(7)*.

Patient safety: The reduction of risk of unnecessary harm associated with health care to an acceptable minimum *(4)*.

Qualification: Official confirmation, usually in the form of a document certifying the successful completion of an educational programme or a stage of a programme. Qualifications can be obtained through:

(1) successful completion of a full programme; (2) successful completion of a stage of a programme (intermediate qualifications); or (3) validation of acquired knowledge, skills and competencies that is independent of participation in such programmes *(8)*.

Regulation (for health practitioners): All laws or rules that govern an individual's entry to health practitioner education programmes, entry to practice, registration, licensure, scope of practice, maintenance of practice standards, disciplinary actions for deviation from regulatory standards, and associated linkages with the health system – adapted from *(9)*.

Subjects of health practitioner regulation: The occupation or group of individuals to whom regulation applies (including practitioners and the registrants) *(7)*.

Traditional medicine: The sum total of the knowledge, skills 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 *(2)*.

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Executive summary

Introduction

The regulation of health practitioners is an essential strategy to minimize instances of patient harm in health services by enabling access to practitioners who meet minimum criteria for patient safety. Although the models of regulation vary, regulatory functions include the following: defining and enforcing education standards; defining the minimum levels for competence and conduct of health practitioners; investigating complaints and enforcing discipline; and informing the public about regulated practitioners. Health practitioner regulation also has the potential to advance other health system priorities and objectives, such as workforce availability, equitable distribution and improved performance.

This guidance highlights the contemporary issues in health practitioner regulation. It discusses challenges in implementing regulatory policies and articulates policy considerations for the design, reform and implementation of regulation. Finally, it highlights evidence gaps and identifies a research agenda.

Objective, scope and target audience

This guidance aims to inform the design, reform and implementation of health practitioner regulation and to strengthen regulatory systems and institutions.

The term “health practitioner” is used to encompass all health professionals, associate health professionals, including community health workers, personal care workers in health services (allopathy as well as traditional, complementary and integrative medicine), health assistants, the public health workforce, and other health practitioners who are yet to be officially classified, but who are directly involved in patient diagnostics or care.

The target audience includes regulators, policy-makers and the wider global health community, including the health service industry, practitioners and academic institutions.

The contents of the document were informed by an integrative review of the literature and by advice from a WHO Technical Expert Group on health practitioner regulation.

Key findings

Health practitioner regulatory systems are very diverse, reflecting differences in national health and education systems, legal traditions, political history, economy, governance structure and other sociocultural aspects. There is also substantial variation in the health professions being regulated and in the type of regulation; moreover, few countries have a defined and objective criterion for regulation. Some regulators use risk-based tools to decide on the most appropriate regulatory mechanism.

Advancing the public interest in terms of patient safety is a commonly stated purpose of health practitioner regulation. Historically, such regulation was considered synonymous with elevating the professions being regulated by defining and protecting them. However, excessive inflexibility and unnecessary barriers to entry to the health labour market raise concerns that the interests of

the professions are being prioritized over public welfare through regulatory capture. Furthermore, fragmented and rigid regulatory systems operating in occupational silos can be disconnected from the broader health objectives and from associated reforms in health service delivery.

The understanding of public interest has evolved over time from elevating the professions to prioritizing patient safety, enhancing cost-effectiveness and aligning with health system needs. Other common principles underlying regulation are its uniformity, transparency and proportionality to risks and benefits. Regulatory reforms have taken place across countries to address different priorities, such as the quality and cost of educating health practitioners, their mobility and sustainability, and the transparency and accountability of regulators. For instance, temporary flexibilities in health practitioner regulation were introduced in many countries during the coronavirus disease (COVID-19) pandemic to increase practitioner availability. This provided a strategic opportunity to review the alignment of regulatory systems with broader priorities, such as universal health coverage and health security.

Regulatory practice gap

Increasing numbers of health occupations are being regulated by law, but large gaps exist between regulatory policies, practices and outcomes. A "regulatory practice gap" may occur when the existing regulatory policy is not implemented in practice, or when it does not meet the intended purpose despite being implemented. While these gaps are also common in countries with mature regulatory systems, they are more prominent in low- and middle-income countries. The factors that contribute to the regulatory practice gap include: inappropriate regulatory models; logical assumptions being given precedence over evidence; regulators having limited capacity to carry out their functions, in part because of the size of the workforce to be regulated; and weak governance.

Limitations

Nearly all (99.5%) of the published literature on health practitioner regulation reviewed for this guidance was descriptive. Most of the available evidence refers to Australia, Canada, New Zealand, the United Kingdom and the United States, and focuses on medical, nursing and midwifery personnel. This limits its generalizability to selected professions in member countries of the Organisation for Economic Co-operation and Development. The lack of a common terminology and taxonomy used in regulation further complicates the retrieval and analysis of evidence, and the comparison of national experiences and practices. Moreover, there is little evidence on how effective regulatory systems are in influencing patient health outcomes. This leaves little room for drawing up comprehensive evidence-based recommendations. The evidence base also overlooks the role of gender norms, roles and relations in regulation and, therefore, any potential gender differences in the regulatory impact on health practitioners as well as patients. This constrains the development of gender-responsive policy considerations.

Nevertheless, the findings provide a good basis for understanding the contemporary regulatory landscape and identifying common principles and key elements for policy considerations.

Key considerations

Health practitioner regulation should strike the right balance between addressing the risk of harm to patients and ensuring public access to health services. Under-regulation can place patients at risk of harm from health practitioners, while over-regulation can place the public at risk of harm by reducing or removing access to health services.

It is therefore essential that regulators define patient harm in the specific context, review existing mechanisms for patient safety in terms of the intended goals and identify the reasons behind any divergence. They should also understand the extent to which health practitioner regulation can address the identified gap, their capacity to implement the regulatory measures, and the (direct and indirect) costs and negative consequences that regulation may impose on the health labour market and the health system. The regulatory practice gap can then be reduced by introducing appropriate measures. Additional and/or more stringent regulatory measures are resource-intensive and may prove challenging to implement. Therefore, depending on the context, alternative interventions could be more effective.

A universally applicable, ideal model of a health practitioner regulatory system does not exist. This is because regulation needs to be responsive to individual health system priorities and specificities, which vary between countries. Each country differs in its health system architecture and health service delivery profile, including its system of occupational regulation and the composition and division of labour in its health workforce. A country's understanding of patient harm may also be influenced by cultural norms. Therefore, health practitioner regulatory systems and their appropriateness should be evaluated periodically to identify any need for reform. Such reforms may range from incremental changes to an overhaul of the entire regulatory system.

Dynamic, effective and agile health practitioner regulation is required to respond to complex health system needs and to keep pace with public expectations. To encourage countries to contextualize health practitioner regulation by focusing on the outcomes, this guidance suggests a progressive process of assessing regulatory gaps and identifying the most appropriate interventions:

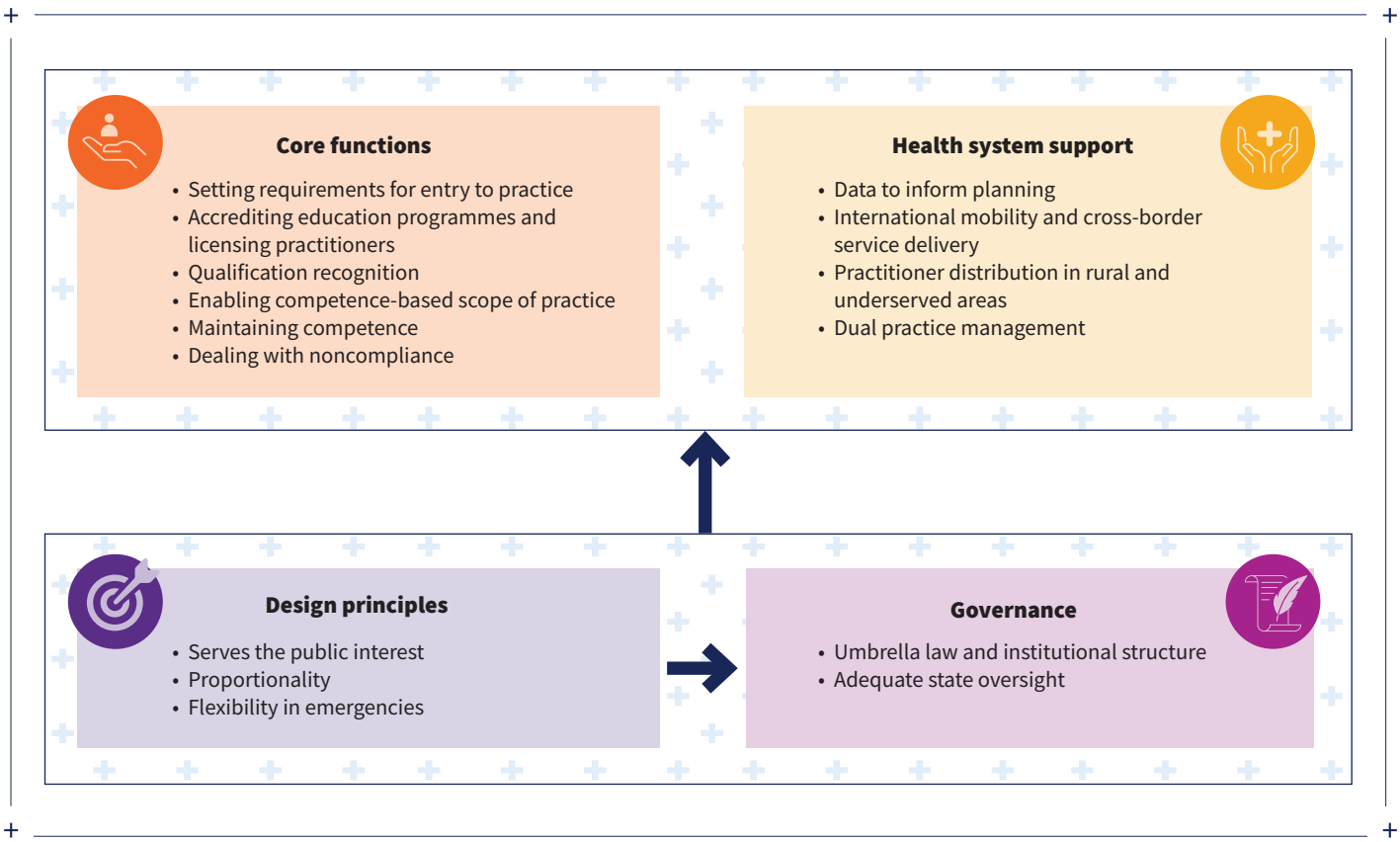
(1) understanding the local context and existing systems
(2) identifying the main challenges
(3) determining the desired outcomes
(4) assessing the risk of harm from practitioners
(5) deliberating on risk reduction options and the associated impact
(6) developing and testing regulatory interventions
(7) managing capacity requirements
(8) monitoring and evaluation of the regulatory interventions and outcomes.

This guidance presents common principles, key policy considerations and core elements for the design, reform and implementation of health practitioner regulation. The policy considerations on regulation design, reform and implementation are summarized below (Fig. 1), grouped into four categories:

(1)Design principles
(2)Governance
(3)Core functions
(4)Health system support

The generalizability and applicability of these policy considerations may vary substantially across settings. This should be considered before being adapted as deemed relevant to the local context.

Fig. 1.
Key policy considerations



Chapter 1

Background

"The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition" *(1)*. This right to health can only be fully realized when health practitioners provide safe services in the best interests of the population. However, health workforce shortages and variations in the quality of care are obstacles to achieving this. As adverse events due to unsafe care are important causes of death and disability *(2)*, ensuring the competence and ethical behaviour of health practitioners is essential in minimizing patient harm in health care settings and contributing to the quality of the services that practitioners provide.

Occupational regulation can be described as "the legally defined requirements or rules that govern entry into occupations and subsequent conduct within them" *(3)*. Regulation plays an important role in ensuring access to and the quality of health services. WHO's *Global strategy on human resources for health: workforce 2030* emphasizes the importance of effective health practitioner regulation in achieving the United Nations Sustainable Development Goal (SDG) on good health and well-being. The global strategy points to the role of health practitioner regulation in optimizing the existing health workforce while also better aligning health workforce investments with health system needs *(4)*.

Patient safety requires a framework of organized activities to create cultures, processes, behaviours, technologies and environments that consistently and sustainably lower risk, reduce the occurrence of avoidable harm, make errors less likely and/or reduce their consequences *(2)*. For health practitioners, patient safety means that those using their services should not be harmed by their advice or intervention and should receive the correct management. However, multiple factors contribute to the safe provision of health services and the practitioner's ability to provide correct diagnosis and care. Health practitioner regulation is only one of several strategies required to minimize avoidable patient harm.

The purpose of regulation is to serve the public interest and protect the public. The risk of harm from health advice or intervention and the asymmetry of knowledge between the practitioners and the public necessitate a mechanism to identify practitioners who are competent to provide safe care and are responsive to the public's health service needs. An earlier interpretation of public interest saw it as synonymous with supporting and advancing the health professions. In the 21st century, the term encompasses: enhancing efficiency; making regulatory intervention proportional to the risks presented by the practitioner and benefits from regulation to the public; ensuring cost effectiveness; responding to the public's expectations; increasing choice within health service/practitioners' options; and addressing the complex and emerging needs of health systems *(5)*. This broader understanding of public interest can cause tensions in regulation because historically (and, in some cases, currently) statutory regulation in some countries has been led by the professions themselves. For them, protecting their professional turf, advancing the economic interests of the profession and securing authority and prestige were priorities alongside patient safety *(6, 7)*.

The functions of licensing schemes depend on the system of regulation adopted and the type of health occupation being regulated. They generally include the establishment of educational standards, quality assurance for education programmes, codes of conduct for practitioners, standard-setting for entry to practice, the maintenance of registers with information about those fit to practice, the maintenance of practice standards and appropriate regulatory measures in cases of misconduct or substandard performance.

Regulatory systems for health practitioners have focused on the competence of practitioners and practice standards, on reinforcing policies related to the equitable distribution of practitioners and the appropriate management of dual practice, as well as on broader policies related to health

workers' international mobility and migration. In this context, health practitioner regulation is increasingly recognized as an important lever to enhance health workforce availability, accessibility, acceptability, quality and sustainability *(8)*. Regulation can thus contribute to broader health system objectives and the United Nations SDG targets, particularly by reducing inequalities *(9)*. During the COVID-19 pandemic, reforming health practitioner regulation emerged as a key priority in strengthening primary health care *(10)*.

In addressing these interrelated but sometimes conflicting priorities, contemporary regulatory systems for health practitioners face several challenges, mainly:

(1) **Adapting to the changing landscape of health service delivery and population characteristics.** Regulatory systems should keep pace with changes in health education, service delivery and population characteristics to ensure patient safety and quality. However, they are under pressure from the increasing volume and privatization of health practitioner education, the rising importance of previously unregulated occupations and emergence of new occupations, cross-border education and service delivery (for example, via digital technology), the increasing focus on team-based and integrated service delivery and growing consumer knowledge and expectations of more efficient services *(11)*.

(2) **Ensuring a fit-for-purpose health workforce.** The availability, distribution and quality of the global health workforce remains a major challenge to achieving universal health coverage and health security. Regulation can contribute to addressing imbalances in the health labour market. However, its core purpose is to assure that the health workforce has the minimum competence required to deliver safe services that respond to rapidly evolving health system needs.

(3) **Maintaining public trust.** The public's trust in practitioners and regulators is tested when health practitioners and regulators act in their own self-interest. Where they are driven by financial profit or turf protection instead of the patient's interest, practitioners may compete for market space. The historically dual purpose of regulation in some countries and the contemporary understanding of the public interest make additional efforts crucial to maintain legitimacy and public trust in the regulatory system and in the health workforce *(6)*.

(4) **Responding to priority needs.** Public health emergencies, such as the COVID-19 pandemic, humanitarian crises, disasters and conflicts highlight the need for health systems to be responsive and resilient to shocks. This requires regulatory systems that enable health practitioners to offer integrated, responsive, continuous and community-oriented care, and to be prepared for emergencies s *(10)*.

Reforms in the scope, structure, functions and governance of health practitioner regulation can at times be disconnected from broader health reform agendas *(12, 13)*. They may fail to adequately align with the local population's health priorities and public expectations for services *(14)*. There are also concerns about regulation being used to secure the interests of regulators and practitioners, as opposed to serving the public *(15–19)*.

The potential impact of health practitioner regulation on gender disparities also deserves attention. Approximately 67% of the health workforce are women *(20)*. Compared to their male colleagues, women are more likely to be unpaid or underpaid and to experience workplace violence, injuries, harassment and discrimination *(21, 22)*. Similarly, regulation could have unintended effects on practitioners of different ethnicities, colours, nationalities and religions.

Health practitioner regulation needs to pursue two complementary objectives: patient safety and public access to health services required to improve population health and well-being that are affordable. For this, regulation should be proportionate to the likelihood of harm occurring and the likely impact of the regulatory action on public health *(11, 23)*.

Health practitioner regulation encompasses multiple aims and stakeholders, with substantial diversity in structure and operation across geographical, linguistic, political and economic systems. However, some commonalities exist in the regulatory approaches, practices and priority functions. This guidance documents a consolidation of both long-standing and emerging challenges and an appraisal of the evidence and innovations in health practitioner regulation. It also outlines a contemporary regulation agenda for improving workforce availability and distribution, setting minimum standards for service provision and patient safety, and ultimately improving population health outcomes.

This guidance addresses these issues in depth in the following order:

- the objectives and methods adopted in the process of developing the guidance (Chapter 2)
- a synthesis of available evidence that describes the contemporary regulatory landscape (Chapter 3)
- the process to assess and minimize the regulatory practice gap (Chapter 4)
- key policy considerations for the design, reform and strengthening of health practitioner regulation (Chapter 5)
- evidence gaps and research agenda (Chapter 6).

Chapter 2

Objectives and methods

In seeking to support countries to strengthen health practitioner regulatory systems and improve population health, the specific objectives of the guidance are to:

(1) document the diversity of regulatory systems for health practitioners and the respective challenges to ensuring the quality and sustainability of health workforce education and practice;
(2) identify innovations in health practitioner regulation, including specific reforms of the overall objectives, institutional framework, regulatory and operational mechanisms and regulatory capacity;
(3) identify empirical evidence, where available, on the impact such innovations have on health practitioner regulation, with a focus on health governance and occupational regulation systems; and
(4) provide recommendations to governments and regulators on key considerations, common principles and core elements for the design, reform and strengthening of regulatory systems for health practitioners.

Target audience

This guidance has been primarily developed for policy-makers and regulators at national or subnational levels, and across policy areas such as health, education, labour and the international trade in services. It is relevant for countries at all levels of socioeconomic development. The secondary target audience includes academics and researchers, civil society, the public, health practitioners, the media, and different health occupations' professional associations, representatives, trainers and educators.

Scope

This is the first comprehensive global normative product produced by WHO on health practitioner regulation. While broader employment regulation and occupational health and safety regulations in a jurisdiction apply to all workers, including health practitioners, this guidance focuses on the specific elements of regulating health practitioners, for example, their education, entry to practice, scope of practice, competence, ethical behaviour, complaints and disciplinary actions, and their linkage with health systems.

The term "health practitioner" is used here to encompass all health professionals, associate health professionals, including community health workers, health care assistants and personal care workers in health services (allopathy as well as traditional, complementary and integrative medicine) as defined in the International Standard Classification of Occupations (ISCO-08) (24), the public health workforce, and new or other health practitioners who are yet to come under an official international classification. This definition of health practitioner excludes members of the health workforce who are not directly engaged with patient diagnostics or care, such as staff in management, administration, operations, logistics and support roles.

Method

Development process

An iterative process to conceptualize the scope of work was used during the development of this guidance, followed by critical appraisal and interpretation of the evidence and translation into policy considerations. Key elements in the development were as follows.

(1) **Technical Expert Group advice**
The Technical Expert Group (TEG) on health practitioner regulation contributed to the identification, prioritization and categorization of topics to be addressed, the interpretation of the evidence gathered and the validation of research methods and findings. It further provided expert advice on topics where available evidence was limited to formulate the policy considerations. The TEG operated by consensus; no voting was necessary.

(2) **Scoping review of health practitioner regulation**
The WHO Secretariat conducted an initial scoping review of health practitioner regulation to inform the first discussion of the TEG, to help to determine the focus of the guidance, and steer the development of the systematic review research questions *(25)* (Mahat and Dhillon [WHO], unpublished data, [2022]). The findings from this review were used in developing the terms of reference for the integrative review.

(3) **Integrative review of health practitioner regulation**
The integrative review assessed the available evidence on the structure, processes and outcomes of health practitioner regulation. It was based on the preliminary findings of the scoping review and the prioritization of topics by the TEG. It placed particular emphasis on questions and policy domains identified by the WHO Secretariat in consultation with the TEG *(26, 27)*. The methodology used during both the integrative review and scoping review are presented in the Annex.

The results of the scoping and integrative literature reviews were supplemented by expert opinions from the TEG to inform policy considerations on the design, reform and implementation of health practitioner regulation.

[1] Available on request.

Chapter 3

The contemporary regulatory landscape: key findings and issues

This chapter summarizes the results of the evidence analysis drawn from the integrative review, unless stated otherwise. Specific sections are complemented by additional evidence identified by the Secretariat or the TEG during its deliberations. The key findings have been organized into seven themes: (1) diversity of regulatory systems and approaches; (2) regulatory functions and mechanisms; (3) effects of health practitioner regulation on health services; (4) regulatory reforms and innovation; (5) experience from the COVID-19 pandemic; (6) challenges particularly relevant in LMICs; and (7) the regulatory practice gap. These themes describe the diversity of regulatory systems, identify innovations and highlight the empirical evidence on the reforms and implementation challenges encountered in many countries. The approach to overcoming these implementation gaps and the policy considerations for the design, reform and strengthening of health practitioner regulation are described in subsequent chapters.

The integrative review included 410 peer-reviewed articles and 426 grey literature sources *(26)*. Half the peer-reviewed literature (50.5%) concerned medical, nursing and midwifery personnel and referred to Australia, Canada, New Zealand, the United Kingdom and the United States. Among the peer-reviewed studies, 99.5% (408 out of 410) were descriptive; the review did not identify quantitative studies (such as econometric, modelling and difference–indifference analyses) that would enable causal inferences to be drawn between regulations and their effects. Consequently, this body of evidence in the aggregate is not generalizable.

3.1 Diversity of regulatory systems and approaches

Regulation[2] for health practitioners encompasses all laws or rules that govern an individual's entry to health practitioner education programmes, entry to practice, registration, licensure, scope of practice, maintenance of practice standards, disciplinary actions for deviation from regulatory standards and associated linkages with the health system *(26)*. These rules can be established through statutory or non-statutory regulation schemes.

The aims and principles of regulation

The most commonly stated objective of health practitioner regulation is to promote patient safety, that is, to reduce the likelihood of harm occurring due to practitioner misconduct or incompetence (error, neglect or malpractice). In some contexts, the role of health practitioner regulators also includes promoting the professions *(26)*; in others, this function has been left to the professional associations and trade unions *(28)*. Contemporary health practitioner regulation also considers broader health system priorities, such as: access to health services through

[2] The definition of regulation depends on the problem or issue being considered. The literature review concentrated on the rules promulgated by the government or professional bodies under delegation from or recognized by the government, in alignment with Koop and Lodge and OECD definitions of regulation. It also included voluntary schemes, typically run by professional associations, where there is little or no government involvement.

improved availability, distribution and utilization of health practitioners; promotion of interdisciplinary collaboration and cooperation in health service delivery; geographical balance and social justice in health practitioner education; workforce flexibility, mobility and sustainability; and progress towards universal health coverage *(29–32)*.

Regulators and standard-setting bodies use a range of principles for regulation. Some suggest that principles for "good regulation" include mandate, accountability, transparency, expertise and efficiency *(33)*. Others place the emphasis on role clarity, preventing undue influence and maintaining trust, having a decision-making and governing-body structure for independent regulators, accountability and transparency, engagement, funding and performance evaluation *(34)*. Some international bodies outline principles such as purposefulness, definition, professional ultimacy, collaboration, representational balance, flexibility, efficiency, universality, natural justice, transparency, accountability and effectiveness, which together can guide the development and evaluation of professional regulatory systems *(35)*.

A regulatory system is considered to be well designed when it does not create unnecessary financial and administrative burdens or other economic costs, is focused on and appropriately addresses risks to public safety, is proportional to the potential benefits and is flexible enough to work effectively for different health service needs and approaches (36). Effective regulation should include an appraisal of potential, actual and perceived harm in the context in which it is applied.

The review found support for the notion that the design of regulatory systems should explicitly consider the actual or potential economic impact of professional regulation and attempt to minimize it. This includes the cost to registrants of fees, the costs to governments of either subsidizing those fees or giving tax relief to those who pay them, the cost of employing regulated people and the overall burden of regulatory compliance on health systems. Where regulation creates a supply-side shortage, some impacts can be reflected in the price of services.

The scope of health practitioner regulation

The review found considerable variation between countries in which health practitioners are regulated and how they are regulated. While statutory regulation of health professionals is more common, some countries also regulate associate health professionals and health care assistants. An increasing number of countries are also regulating additional health occupations including traditional, complementary and integrative medicine (TCIM) practitioners are also regulated.

Contextual factors profoundly influence who is regulated and by what mechanism. These factors include the architecture of the health system, the division of labour among occupational groups, institutional legacies and population health needs. Some countries have established regulatory assessment processes to avoid unnecessary restrictions on competition and to minimize regulatory burden and costs *(37, 38)*. However, objective criteria for deciding which practitioners should be regulated and which mechanism of regulation is the most appropriate are typically not made explicit. Some regulators use risk-based regulation tools to better decide on the most appropriate mechanisms, weighing the risk to the public against improved access to health services *(39)*. The "Right-touch regulation", developed in the United Kingdom, aims to be proportionate, consistent, targeted, transparent, accountable and agile in reducing actual harm. It follows a decision tree when introducing a new regulatory measure for health practitioners (see Fig. 2) *(40)*.

Governance and institutional structure of health practitioner regulation

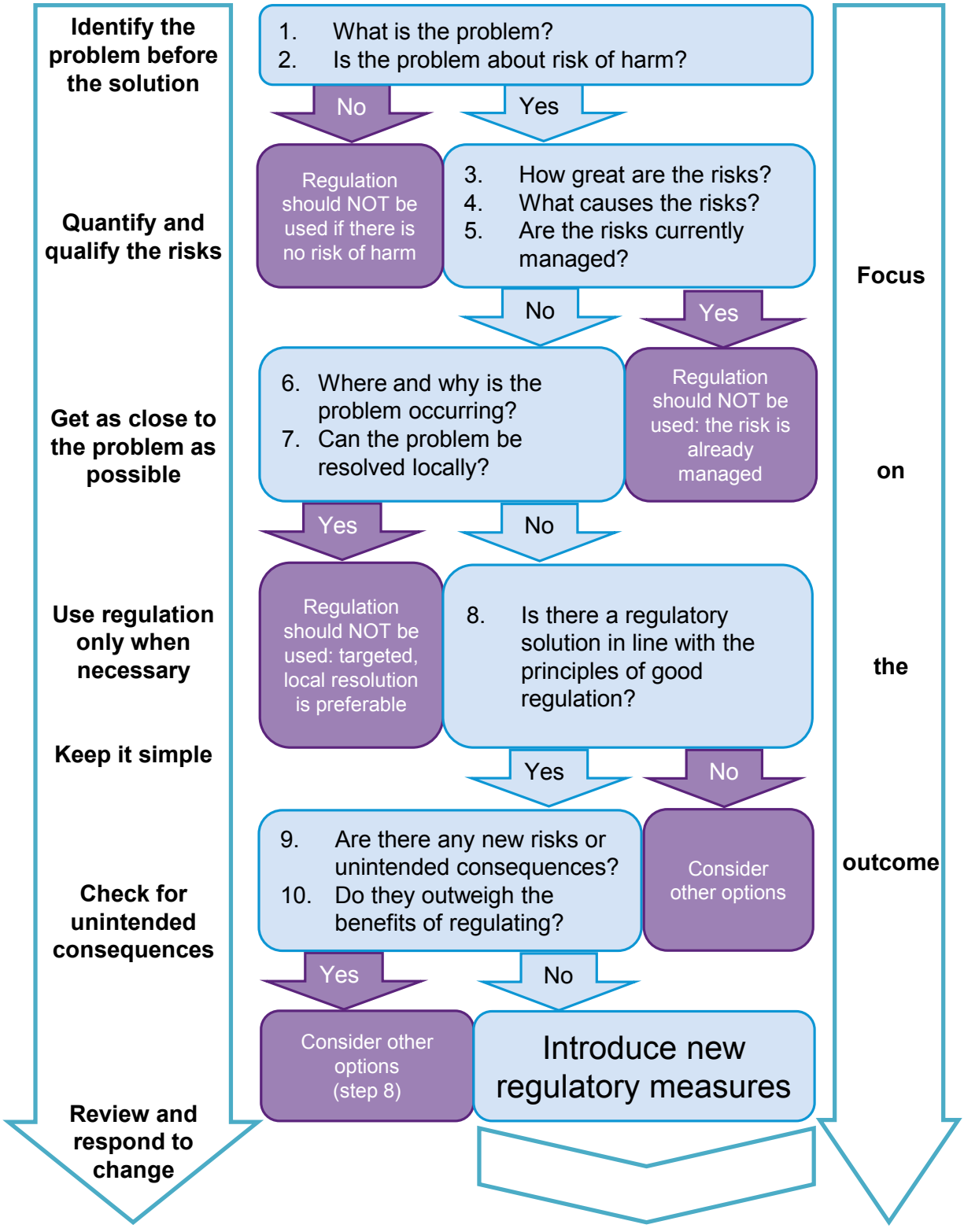
Health practitioner regulation does not occur in a vacuum. It is shaped by the objectives, principles and approaches that inform regulation in general, including by other (non-health) occupations. The review found substantial diversity in the structure of regulatory systems for health practitioners, which are influenced by the country's governance structure and institutional traditions (Table 1).

The way in which health practitioner regulation is structured and operates differs across national and subnational jurisdictions, across occupations and functions, across linguistic systems and across political-economic models and legal traditions *(25)*. Differences due to dissimilar systems of governance and political history are particularly notable between Anglophone, Francophone, Hispanophone and Lusophone countries, and the centrally planned former socialist economies. Regulation for health practitioners is also influenced by the health, education and legal systems (including broader regulatory mechanisms for other occupations); the extent of their penetration into communities (Fig. 3); the market for health services and health financing mechanisms *(25)*.

The mandated role of the regulatory authority, State, occupations and civil society varies across countries and jurisdictions. Accordingly, the model of health practitioner regulation ranges widely, with differences across occupations and regulatory functions: from professional autonomy and independent statutory authority models to government-administered and co-regulation models. Health practitioners in some

Fig. 2.

The Right-touch regulation decision tree



Source: reproduced with permission from the Professional Standards Authority *(40)*.

associate health professional or assistant roles may only be regulated via generic provisions that apply to all members of society or through other provisions rather than by a specific occupational regulation. Moreover, there are no standard operational definitions of the terms used, such as "independent", "autonomous", "profession-led", "self-regulation", "self-governed" or "government-led", which can often have different meanings across countries.

Conflicts of interest can occur in both statutory profession-led regulation and direct government regulation. Health professionals typically have altruistic codes of ethics oriented towards patients, users or the wider public. Yet, in cases of competing interests, professional self-interests could prevail. Regulatory reviews in several countries suggest the need for greater government oversight because the lack of transparency in profession-led regulatory schemes can allow the practitioners' interests to be prioritized over public welfare, especially when the decision-makers are also active participants in the health labour market *(41–43)*.

In federated contexts, some countries have a single national law for health practitioner regulation, whereas others have jurisdiction-specific regulatory systems. Some countries have opted for a national law and single institution for regulation to increase efficiency. However, the TEG highlighted that in contexts with substantial diversity within a country, or with different levels of government responsible for health service delivery and health practitioner regulation, it can be challenging to align regulation with the needs of both the health system and the population using a common national standard *(44, 45)*. In some settings, umbrella boards are more likely to be assessed using the sunset review process. By contrast, independent boards may be more communicative with their stakeholders and more efficient in meeting national standards and have greater autonomy *(46, 47)*. Differences in regulatory

Table 1.

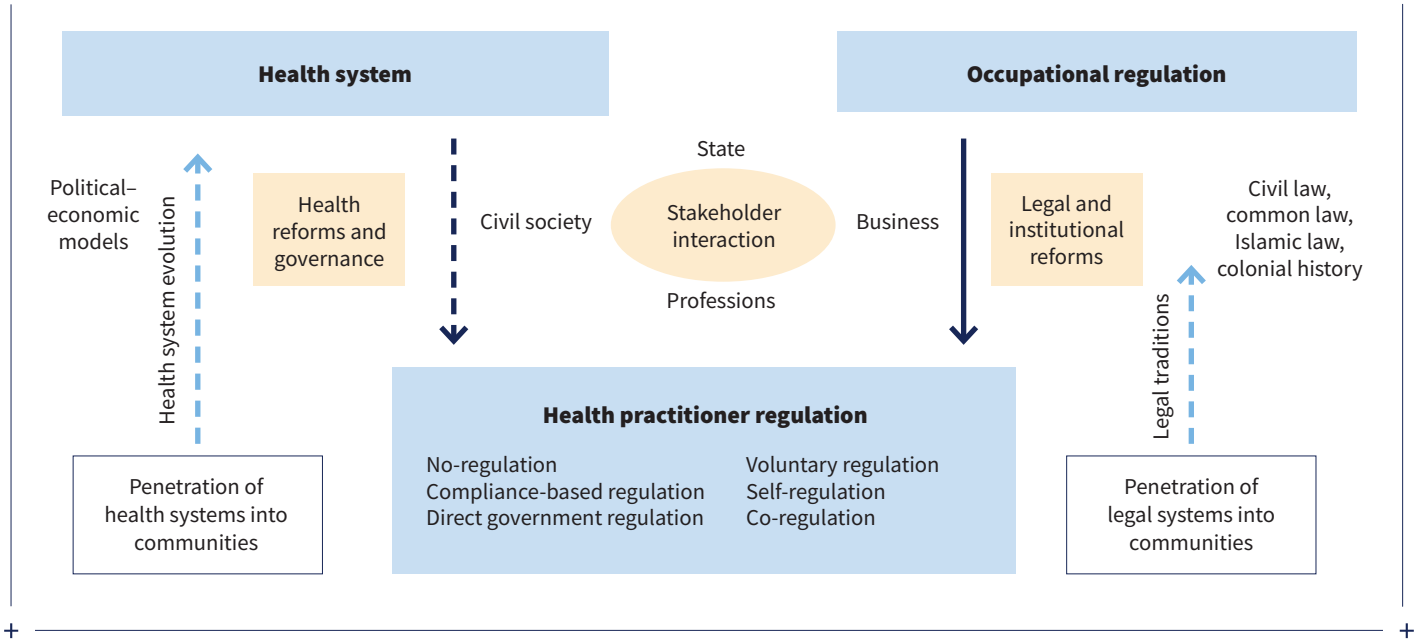
The diversity of regulatory models for health practitioners

Legitimacy	Geographical scope	Governance model	Administering entity
Statutory regulation The regulatory system is established by legislation, and regulation is compulsory for health occupations covered by the law. There could be a single law or legal framework for all health occupations and/or regulatory functions or else multiple laws, each specific to one or more health occupations and/or functions. **Nonstatutory regulation** is established by professional associations or other entities and does not impose a legal obligation for members or individual practitioners to be regulated.	**National regulation** The law (and associated standards, processes, etc.) applies to an entire country. **Subnational regulation** is Specific to subnational territories (jurisdictions).	In **government-led** regulation, regulatory functions are led and delivered directly by the government (for example, health ministry, education ministry or government agency). **Profession-led** boards are led by the professions being regulated. Members may be elected or else nominated by professional associations, educational institutions, government agencies or the responsible minister. An **independent authority** is a corporate body that may be constituted by a combination of personnel (from, for example, the profession being regulated, the government, the public and educational institutions) and has the power to employ staff and perform regulatory functions. An **oversight authority/meta regulator** provides oversight to individual regulators.	The entity to enforce regulations may be a **single agency** with different boards responsible for different occupations and/ or functions, or separate **occupation-specific bodies or function-specific bodies**. These may reside within government institutions or professional associations or could be an independent or semi-autonomous body established for the purpose.

Different combinations of the above can also exist within and across countries for different health occupations and regulatory functions.

Fig. 3.

Contextual determinants for the design of health practitioner regulation



Source: adapted from*(25)*.

schemes at subnational levels can also encourage competition and innovation. To address the blind spots of national regulation, some researchers have proposed an "ambidextrous" approach, whereby certain regulatory functions are centrally managed while others are deconcentrated *(45)*.

Financing models are an important feature of the design and operation of a regulatory system. Common sources of funding for regulatory agencies are fees from licensing, the registration and certification of practitioners, accreditation of health professional training institutions, penalties and government or employer contributions. Regulatory systems can thus generate revenue for the regulatory agency *(48)*. Regulators with many regulated subjects and performing several functions can generate more revenue to meet operational costs. However, for practitioners with a lower risk profile or a limited number of subjects, resource constraints could be a barrier to maintaining basic regulatory functions. Registration fees represent costs for the practitioners. These costs may be subsidized through financial support directly to the regulator or through tax relief to the regulated person. However, health occupations with lower remuneration may contribute a higher proportion of their income to comply with regulatory requirements than health practitioners with higher remuneration.

Reservation of title and reservation of practice

Statutory regulation of health practitioners normally includes the reservation of professional titles and/or reservation of practice (tasks or activities).

The reservation of professional title forbids anyone but the licensed practitioner from using the restricted professional title. However, the scope of practice[3] *(49)* of individual practitioners may be allowed to expand within reasonable limits to include additional procedures and tasks based on their competencies, additional training, experience and changes in clinical practice. This flexibility reduces the potential for regulation to be a barrier to updates on the scope of work of health practitioners to enable them to perform additional procedures. It is deemed necessary to preserve access, contain costs and improve patient outcomes *(50–52)*. For example, generalists, nurses and other health professionals, associate health professionals and community health workers can be trained to perform certain procedures normally undertaken only by specialists, physicians and professionals, respectively. Available evidence suggests that health practitioners in LMICs and high-income countries (HICs) can be educated, authorized and supported to safely and competently administer, supply and/or prescribe certain restricted medicines, thereby improving access to quality health services *(53, 54)*.

[3] Scope of practice is the full spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within that profession are educated, competent and authorized to perform."

The reservation of practice prohibits unlicensed personnel from providing certain clinical services. Some laws allow regulators to specify the scope of practice in detail, while others define only the outer boundaries *(55)*. The scope of practice is based on factors such as education, condition of registration, terms of employment, work environment (including delegation and supervision arrangements), funding mechanisms and collaborative practice agreements, and population health needs *(49)*. In team-based care models, the division of labour can generate substantial overlap in scope of practice and shared responsibilities *(56)*. Where the reservation of practice is rigid (through restricted acts, scope of practice and associated offences), this can delay timely reforms and create a monopoly for certain groups of practitioners. Such restrictions can stem from competing economic interests within the division of labour, as opposed to any evidence of a risk of harm to patients *(57–59)*.

Setting rigid boundaries on the scope of practice based exclusively on professional silos, without adequately considering the education and competence of other occupational groups, can have negative consequences on health service delivery, cost and outcomes *(60, 61)*. Those with more flexible scope of practice arrangements show positive impact on workforce outcomes and on primary care *(51, 61–64)*.

Practitioners of traditional, complementary and integrative medicine

The decision to regulate often reflects political, cultural and social norms in addition to regulatory objectives. Recognizing this, the regulation of practitioners specializing in TCIM presents specific challenges. TCIM includes a diverse array of service models and traditions, such as acupuncture, Ayurveda, traditional Chinese medicine, chiropractic, herbal medicine, homeopathy, naturopathy, osteopathy and Unani medicine, among others. The type of TCIM practiced in one jurisdiction may not exist in another. In some instances, the therapeutic approach to healing may present an unclear risk profile, presenting complications in regulatory processes. Where there is a lack of research data and TCIM expertise among health authorities and regulators, the regulatory mechanisms used for practitioners of allopathic medicine may not apply and may need adjustment.

More than 80% of WHO's Member States across all regions use TCIM *(65)*. However, its position within a country and the institutional recognition of its practitioners is often defined by the country's historical, social and professional relation to allopathic medicine *(66–68)*. Laws on regulation can restrict the scope of practice of TCIM practitioners yet protect allopathy practitioners against disciplinary action for practicing therapeutic approaches other than allopathic medicine. Some governments may decide against statutory regulation of TCIM practitioners based on factors such as providing undue credibility to their practices or a lack of threshold requirements and nationally agreed standards of education rather than on patient safety grounds. Other regulators apply evidence-informed policy-making and a regulatory impact assessment process to determine the regulation of TCIM practitioners *(69, 70)*.

Available evidence suggests that the risk profile of some TCIM practitioners with a broad scope of practice warrants statutory regulation. Although in increasing numbers of jurisdictions statutory regulation has been extended to TCIM practitioners, there is variation in the architecture and scope *(66)*. Statutory regulation is also seen in some contexts as a strategy to foster collaborative practices and promote the integration of practitioners into the health system *(71, 72)* while, in others, this approach has been withdrawn.

3.2 Regulatory functions and mechanisms

Although the functions of health practitioner regulation vary, its key attributes are often anchored in licensing schemes, the main elements of which are summarized in Table 2. The core functions of the regulator for the education and practice of health practitioners can include: setting and enforcing standards for education; ethical conduct and professional behaviour; assuring practitioner qualifications, probity and competence for entry into practice; establishing and maintaining a registry of practitioners and ensuring that it is available to the public; monitoring compliance with practice standards and maintenance of competence; investigating noncompliance or departure from standards and conduct; and taking regulatory or disciplinary action as needed to ensure public and patient safety. These are further described below.

(1) Setting and enforcing education standards.
In recent years, the increasing privatization of health practitioner education, regulatory convergence and international requirements have influenced regulatory standards *(36, 73, 74)*. Generally, the lists of institutions or programmes that meet these standards are shared with the public. However, not all regulators share details on adverse findings or decisions following the investigation of complaints against educational institutions.

Table 2.
Health practitioner regulation – functions

Core functions (centred on licensing schemes)
1. Setting and enforcing education standards 2. Informing the public about health practitioners who meet minimum standards through a registry 3. Assuring the competence of practitioners entering practice 4. Setting standards for ethical, personal and professional conduct 5. Monitoring compliance with practice standards and continued competence 6. Investigating noncompliance with standards and taking necessary action
Additional functions
1. Influencing the supply of health practitioners 2. Limiting the cost of health practitioner education incurred by students 3. Improving the geographical distribution of health practitioners 4. Facilitating practitioner mobility and cross-border service provision 5. Informing workforce planning 6. Managing dual practice

(2) Informing the public about health practitioners who meet minimum standards. Regulators generally maintain a registry of regulated practitioners to keep the public informed of those authorized as competent to practice and those who have been suspended or removed from the registry. The level of detail available about practitioners through the regulator's public website varies between regulators, occupations and countries, from a simple verification of registration to details on qualification, and practice and disciplinary history. Different types of registration exist (for example, student, temporary, provisional, limited practice, supervised practice, private practice, public sector practice, independent practice, specialized practice and nonclinical practice). These determine where a health practitioner can work, their scope of work and level of independence *(26)*. While in some countries periodic renewals are required to maintain a practitioner's registration or licence, in others, regulators have limited capacity to maintain a complete registry *(75, 76)*.

There have been calls in some jurisdictions to create a basic registry of assistant health practitioners, given the potential risk associated with their work in hospitals, communities and home-based care with some of the most vulnerable members of the society *(77)*. This requirement, however, varies across countries and jurisdictions and may not exist at all for non-licensed occupations.

(3) Ensuring the competence of practitioners entering practice. Tasks performed by health practitioners that are not expected to pose significant harm to patients may not require minimum standards for entry. Regulators set entry standards for regulated health practitioners based on the risk to patient safety and the health system requirements. Standards vary between countries and occupations but commonly include the following requirements: certification of the completion of relevant training and acquired qualifications, demonstration of competence through examinations, practice experience and any significant medical history that may affect a practitioner's ability to practise. Additional standards or requirements may be set for practitioners who provide services through telehealth. Language fluency, letters of good standing and evidence of work experience may be required for international or migrant practitioners.

(4) Setting standards for ethical, personal and professional conduct. The conduct of health practitioners could pose various risks of harm, ranging from fraud and financial dishonesty to sexual exploitation and abuse of patients or service users. Professional regulators are also responsible for assuring ethical behaviour that should be a part of the personal and professional conduct of practitioners. Some regulators articulate the expected behaviour towards patients in a code of practice, where its violation could result in disciplinary action. To assure entry into the profession of personnel with good

conduct, some regulators require criminal history checks and certification of "good character" along with technical competence. Some regulators also require practitioners to meet defined standards for cultural safety *(78)*.

(5) Monitoring continued competence. Health practitioner regulators set certain (nonclinical) practice standards to maintain registration. Mechanisms for compliance monitoring and assuring practitioner competence differ across regulators and countries. In some settings, health practitioners are expected to maintain competence without the need to comply with explicit standards. In others, continued competence may be assured through direct inspection, continuing education requirements, a minimum practice hours requirement, demonstration of practice, investigation of noncompliance, and performance appraisal or assessment of fitness to practice. In countries that have a validity period for registration or licensing, the conditions for renewal range from the simple payment of a fee to demonstration of competence through various means. Formal revalidation programmes have been adopted in some countries, but these are resource intensive and lack supporting evidence of effectiveness compared with other mechanisms *(26)*.

(6) Investigating and addressing noncompliance with standards. Diverse arrangements exist to deal with complaints and disciplinary matters, but there is little evidence and transparency on how this function is performed or on its results. Legislative provisions on complaints procedures are not always implemented. Disciplinary processes may be decentralized or reside in government departments. In some contexts, the disciplinary process is focused more on fraud than misconduct, suggesting that employers may be managing some of the disciplinary matters *(79)*. In some countries, health practitioners have a legal obligation to report professional misconduct by fellow practitioners *(80, 81)*. In general, health practitioners have the right to appeal for a review of disciplinary decisions, but details on decisions following the investigation of complaints and the disciplinary action taken are not made public by all regulators *(26)*. In certain HICs, formal remediation programmes have yielded positive effects, despite being resource intensive. These programmes are designed to support impaired registrants or those with performance concerns in returning to practice *(82, 83)*.

Regulators in some HICs are using the data on complaints and disciplinary action to shape the design of risk management and preventative strategies *(84, 85)*. In many LMICs, mechanisms for complaint and discipline are weak *(86–88)*.

There is little evidence on how to design and deliver effective complaints and discipline systems that minimize the risk to the public. Some countries have increased public oversight of regulatory bodies and distributed regulatory responsibilities across different bodies to better manage this function, increase transparency, avoid possible conflicts of interest and provide procedural fairness to health practitioners *(89–91)*.

Health practitioner regulation plays a crucial role in upholding the competence of health practitioners, which is fundamental for quality of care. It can also support health workforce planning, supply and distribution to advance health system goals and address priority challenges. The secondary functions of health practitioner regulation are described below.

(1) Influencing the supply of health practitioners. The scoping review identified that, based on contextual specificities, some regulators have the authority to set the ceiling on the annual student intake (in undergraduate and postgraduate education or residency programmes) adjusted to government policies (for example, *numerus clausus*),[4] market conditions or the capacity of training institutions to maintain the quality of training *(32, 92)*. Regulators may also have the authority to influence the geographical location of new educational institutions through directives and/or incentives to establish them in underserved areas *(32)*.

(2) Containing the cost of health practitioner education for students. The scoping review identified that, to a certain extent, health practitioner regulators in some LMICs can regulate the cost incurred by students for their education in the private sector. For example, this has been achieved by not allowing fee inflation for a cohort during the course of the programme, setting ceilings on the fees charged to students, specifying that scholarships be awarded in private institutions, setting the fees charged to a proportion of students in each cohort, granting tuition waivers in public institutions, and encouraging not-for-profit health practitioner training institutions *(30, 32, 93)*.

[4] *Numerus clausus* is the quantitative regulation of students entering into education programmes for health professionals.

(3) **Improving the geographical distribution of practitioners.** Regulation can affect the mobility of health practitioners within a country *(94)*. Many countries have used regulatory approaches such as conditional licensing, scholarships in return for a period of service, introducing select types of practitioners to meet specific community needs, and expanding the scope of practice of certain professions to increase the availability of health workers in underserved areas *(95)*. Regulators also play a role in education strategies to attract practitioners to underserved areas, for instance, by including rural health topics in training curricula, enabling digital technologies in education and practice, and providing accelerated pathways to enter new or specialized health careers *(95, 96)*.

(4) **Facilitating practitioner mobility and cross-border service provision.** Regulatory processes to assess the competence and probity of foreign-trained practitioners are necessary to enable the international mobility of practitioners *(97)*.[5] Some countries have also established regulatory requirements for international health service delivery (including through telehealth consultations) to increase service availability *(98)*. Regulatory standards for education and practice have been harmonized across certain jurisdictions and countries through government-to-government mutual recognition agreements, to make it easier for a health practitioner trained in one country to be eligible to practice in another *(74, 99, 100)*. They have also been encouraged by different regional bodies. However, the standards may be difficult to implement when there are variations between countries in the requirements for entry to practice, maintaining competence and dealing with disciplinary matters *(99, 100)*.

(5) **Informing workforce planning.** Based on data available from regulators, the registries of regulated health practitioners may include information on the number of students in health occupations, active and inactive health practitioners, their personal details, place of education and employment, and the jurisdiction of registration within a country *(48, 101, 102)*. Regulators of health practitioner education (or, in some contexts, a government entity) also have information on the number of approved or actual students in the educational institutions. Governments can use data shared by regulators or triangulate the data with that of other sources to inform workforce planning and mobilize health practitioners during emergencies. In many countries, regulated health professions require a letter of good standing from their regulators to be able to register with the regulator in another country. Such letters can be considered an indirect estimate of the number of practitioners considering moving to another country to work.

(6) **Managing dual practice.** Dual practice can hinder the effective and equitable provision of services in the public sector if practitioners prioritize their efforts in the more remunerative private sector. Countries have applied various mechanisms to address the challenges typically associated with dual practice, ranging from specifying services that practitioners can provide in the private sector to additional regulatory requirements to work in the private sector. However, evidence of the effectiveness of these measures has been limited and may depend on health financing mechanisms, enforceability and the capacity to monitor private sector activity *(103, 104)*. Some researchers suggest that LMICs would gain by allowing dual practice, as it could allow the private sector to indirectly subsidize the public sector where wages for the latter are low *(103)*. Nevertheless, measures are required to prevent or mitigate adverse consequences. Dual practice may reduce the risk of health workers dropping out of the public sector entirely, as they can work for the government while supplementing their public sector wages with private sector income. Furthermore, another argument in favour of dual practice may be that it provides public sector workers with exposure to the innovation and new technologies adopted by the private sector first, although the extent to which these benefits materialize has not been firmly established. In the People's Republic of China, "multi-site practice" permits have been introduced to encourage doctors to work in underserved areas and in primary care, in either the public or private sector *(105)*.

Regulatory mechanisms

Health practitioners within and across countries are a diverse group with varying levels of education and division of work. The services they perform carry variable levels of risk of patient harm that need to be appropriately addressed. Although some studies suggest that alternative mechanisms could provide adequate protection to the public at lower cost, many countries are extending licensing requirements for an increasing number of health professions *(5, 106–108)*. The criteria for deciding which practitioners warrant licensing are variable and are often subject to influence by the different stakeholder groups within

[5] World Trade Organization member economies that have made commitments in health-related professional services have an obligation to "provide for adequate procedures to verify the competence of [foreign] professionals".

the health care and political ecosystem, some of which can be associated with vested interests *(18, 69, 109–111)*.

There is a hierarchy among regulatory mechanisms and nonregulatory options to reduce the risk of harm to the public, starting from the de facto absence of regulation and the default alternative of market competition to mechanisms for progressively increasing levels of control, such as licensing (Fig. 4) *(112)*. Depending on the type of health practitioner and the contextual specificities, a single option or a combination of options may be used to achieve the desired outcome.

Where practitioners are considered to pose a lower risk of patient harm, they may be regulated either by employers or through a voluntary registry or partially by negative licensing. Employer approaches to ensuring that the practitioners provide safe services can include verifying qualifications and the completion of education and training requirements, recruitment screening, the provision of codes of conduct and arrangements for training, supervision and appraisal *(40)*. Other mechanisms for lower risk occupations may include disclosure of quality (for example, qualifications, quality score, certifications, code of conduct, etc.) or voluntary registration to help patients/users make an informed choice.

Some of the common regulatory mechanisms are described below, although the use and interpretation of terms vary between countries.

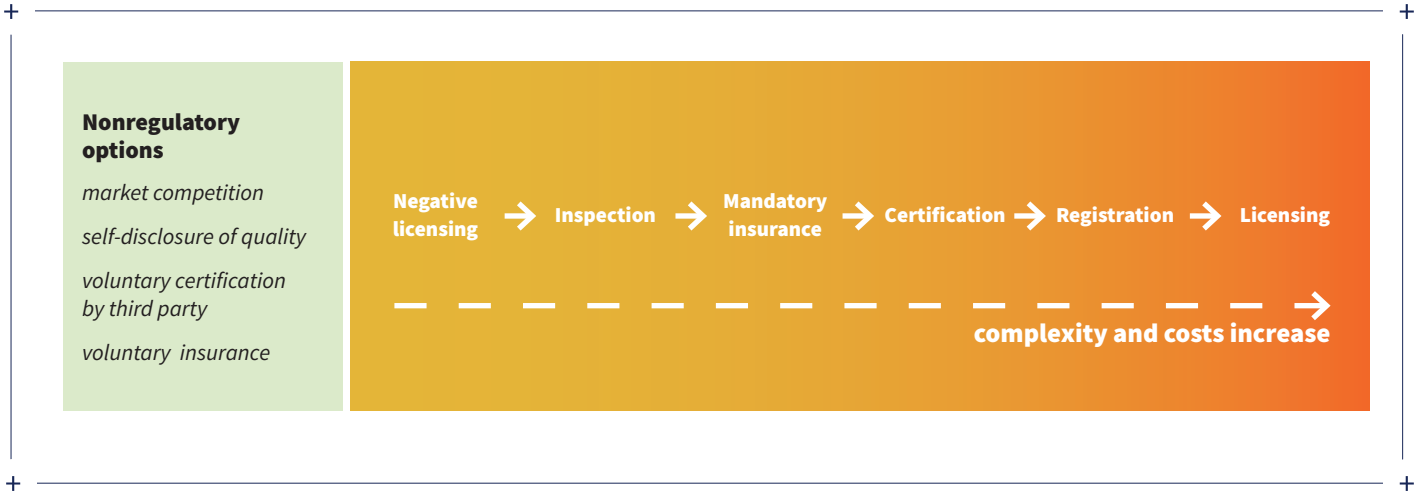
A nonstatutory registry is a **voluntary registry** of practitioners (that is not covered by statutory regulation but established by organizations). These registries may be independently assessed by a regulatory body (established by law) for standards of personal behaviour, technical competence and business practice *(113)*. Practitioners who choose to be part of the registry can use the registration as a quality marker *(114)*.

Negative licensing is an example of a regulatory mechanism from a statutory authority that has been applied to health occupations[6] which are deemed to pose a low risk of harm to the public and are not regulated by professional bodies *(29)*. Under this mechanism, there is typically no barrier for an individual to enter health practice. However, the law allows the regulator to issue a prohibition or banning order if the practitioner is found to have committed an offence, breached the code or engaged in prohibited conduct and if their continued practice presents a serious risk to the public. Breaching a prohibition order may be an offence, and a register of prohibition orders that have been issued is available to the public.

As the level of risk to patient safety increases, other mechanisms, such as certification of training, registration and licensing are applied.

Certification is a mechanism whereby the regulator certifies health practitioners for certain tasks or specialties based on qualification and/or

Fig. 4.
Alternatives to licensing



Source: adapted from *(112)*.

[6] For example, health occupations regulated by professional boards in Australia include Aboriginal and Torres Strait Islander health practice, Chinese medicine, chiropractic, dental, medical, medical radiation practice, nursing and midwifery, occupational therapy, optometry, osteopathy, paramedicine, pharmacy, physiotherapy, podiatry and psychology.

demonstration of competence. There is no legal restriction preventing noncertified personnel from practising the specialty or performing the task. However, employers can choose to employ only certified practitioners, and patients and consumers can decide for themselves whether to use services from noncertified practitioners.

Registration and licensure are used synonymously in many countries, but in others they mean different things *(115)*. Regulators generally require health practitioners providing services with a higher risk profile to record information such as their personal details, qualifications and disciplinary history. This could also include information on criminal records, employment history and mobility as required by the jurisdiction of practice. In the case of licensed practitioners, inclusion in the registry is a legal requirement to practice, but registration can be optional for other practitioners (for example, in voluntary registries). In some countries, registration may not be enough to get a licence to practise. Under a statutory registration scheme, the provider's name is placed on a list of people who are considered qualified to provide a service and they are then entitled to use a reserved professional title *(26)*. The requirement for registration, the type and duration of registration validity, and the level of personal details recorded in the registry or made available to the public differ across occupations and countries.

Licensing is the most restrictive form of regulation. Here, regulators have the statutory authority to restrict entry to practice (in their jurisdiction) to those who they consider to be adequately qualified and of good character (as defined by licensing requirements). Under a licensing scheme, only those practitioners who hold a licence can, beyond using a reserved professional title, practice or carry out specified tasks or restricted activities, with the law defining the scope of practice in some countries *(26)*. Licensing generally involves being listed in a registry. Since licensing represents a powerful barrier to market entry, it has consequences for the health labour market *(16)*. These include the risk of it being misused to reduce competition, which increases costs and restricts access for patients.

Accreditation of educational institutions or programmes of study may be undertaken under different governance arrangements to determine if they are fit to equip students with the minimum competence required for health service delivery. Accreditation can be aligned with the entry-to-practice standards determined by the regulator. In that case, it is also a tool to manage different priorities between the educational institutions (which have academic freedom and autonomy) and the regulators (vested with a public policy and protection mandate). Depending on the risk profile, a diploma or degree from accredited programmes or institutions may be enough to enter practice. Alternatively, it may be one of several requirements for entering practice. In some cases, accreditation may not be mandatory, for example, where education programmes or institutions are run by governments.

Among countries where accreditation is a requirement, there are variations in the entity responsible for the delivery of accreditation functions, standards and processes. Accreditation of health practitioner education programmes or institutions may rest within or outside of the health sector (for example, in education). Many governments may have insufficient levers to influence the quality and appropriateness of education programmes to meet population health needs and health system objectives. In some countries, effective interfaces between the health and education systems are underdeveloped, and the enforcement of accreditation standards is weak *(116)*. There is limited evidence that accreditation systems are cost-effective in assuring the quality of education programmes *(117, 118)*. Nevertheless, more countries are introducing accreditation as a tool to ensure the quality of health practitioner education and to progress towards other social goals. Some regulators require competency-based approaches to training and assessing students to qualify them for entry to practice *(119)*.

Qualification recognition identifies the similarities (and differences) between countries or jurisdictions in training and learning programmes and/or competency requirements for specific occupations. This may be the responsibility of the regulator or another entity commissioned for this purpose. Assessment of qualification determines if the qualification acquired in another jurisdiction meets the pre-defined entry-to-practice standards of specific health practitioner education programmes, including practical training in the country or jurisdiction. Any significant difference in the education programme or practical training may be addressed by compensatory measures, such as the completion of specified education programme(s) and/or supervised practice for a defined period. Subject to contextual requirements, qualification recognition alone may not necessarily be enough to enter practice. Some countries may also require practitioners to undergo specific training, such as residency, regardless of prior qualification *(120)*.

A national licensing examination (NLE)[7] is used to determine if individual health practitioners have

[7] This term is also meant to encompass examinations conducted by regulators at the subnational level, such as the state or province.

the minimum knowledge and skills in the subject to enter practice in a country or jurisdiction. It is either conducted by a health practitioner regulator or commissioned to another entity. The licensing exam requirement, its contents and how it is conducted can vary across countries and health practitioner groups. Despite weak evidence on the effectiveness of NLEs, they are commonly used for licensing or registration. NLEs can be used in response to the growth in private educational institutions and in the mobility of health practitioners with qualifications acquired in another jurisdiction *(121, 122)*.

Continuing professional development (CPD) can be mandatory for health practitioners to maintain registration in many HICs. A simple attendance or a time-based course measurement of CPD programmes is the most common method used by the regulator to determine competence to maintain practice. However, CPD cannot be regarded as effective without measuring its learning outcomes. For example, without correlating CPD activities with a reduction in complaints against practitioners in the associated area or with changes in practitioner behaviour, it is unclear whether they are beneficial or effective in all cases. The cost of CPD requirements to maintain the registration (or licensing) of health practitioners who work part-time may discourage practitioner compliance. Available evidence supports the use of outcome-focused CPD models that use multiple education techniques, which are based on the needs of practitioners and relevant to the environment in which they work *(123, 124)*.

In LMICs, CPD has been used to upskill regulated and unregulated health practitioners. However, mandatory CPD can be difficult to enforce. Additional challenges include: resource constraints; the lack of quality assurance of CPD programmes; disparities in access; mismatches between available programmes and practice needs; and the lack of outcome measurement *(125–127)*.

The requirements for health practitioners to enter practice vary depending on the risk profile of the health occupation and the specific country context. Education requirements may include specifying the number of years of schooling and the type of qualifications that are awarded from government-run institutions, recognized accredited institutions or programmes, or from apprenticeship programmes. Other requirements to be eligible to practice can include a licensing exam, registration and practice experience.

Regulators set the minimum requirements for practice for health professions presenting risk of harm to patients. However, in some settings, governments, employers and consumers can make practice additionally conditional on certification, indemnity coverage and a practice licence. Table 3 presents examples of the steps involved for an individual to enter general and specialty medical practice in three countries.

Table 3.

Education route and requirements for general and specialty medical practice in three countries[8,9]

Education route	Nepal (lower middle-income country) *(32, 128–131)*	China (upper middle-income country) *(105, 132–134)*	United States (high-income country) *(133,135–137)*
Entry into medical school	1. High school (science) graduation OR health associate diploma after 10 years of schooling and equivalency certificate with high school (science) 2. Common entrance exam to be eligible for admission to public and private medical schools and for permission to study medicine abroad (applicants with the highest score matched under merit-based and reservation category scholarships in public and private medical schools)	1. High school graduation 2. National College Entrance Exam for admission into public and private medical schools	1. 3–4 years of undergraduate diploma after high school graduation 2. Standardized test score for individual application to public and private medical schools
Entry into medical practice and/or specialty training	3. Graduation from accredited medical school (5.5 years including one-year clinical training) 4. National licensing exam for a temporary registration 5. Permanent registration (valid for life and required for independent practice) available two years after temporary registration; those who studied medicine on a scholarship are eligible for permanent registration only after completion of two years of service in a government-deployed health facility 6. At least one year of general practice before being eligible for a common qualifying exam for specialty training 7. Common entrance exam to be matched to three-year specialist training (scholarship holders required to serve in government deployed health facility for two years after training)	3. Graduation from accredited medical school (five years including one-year clinical training) plus clinical training in matched programme (three years) 4. National medical licensing exam for Medical Practitioner's Qualification Certificate* 5. Certification of residency completion required for employment 6. Practice licence for employment in jurisdiction of practice; multisite licence to work for more than one employer (in underserved areas in the public or private sector) with the consent of employers and local authority 7. Competence exams every two years 8. Eligible to apply for independent medical practice after five years of practice 9. Malpractice insurance mandatory. *Assistant doctors with vocational diploma or secondary vocational diploma also eligible to sit for the licensing exam after working as assistant doctor for a certain number of years	3. Graduation from accredited medical school (four years) + clinical training (residency) in matched medical programme (3–5 years) 4. National medical licensing exam (multiple steps) 5. Board certification exam for certification (validity period variable) 6. State practice licence (no exams) required to practice in the jurisdiction (1–2-year validity) 7. Malpractice insurance mandatory
Entry into specialty practice	8. National licensing exam for specialist registration (specialist registration valid for life) 9. Three-year subspecialty clinical training in matched accredited programme (scholarship recipients should serve in government deployed health facility for two years) 10. Registration for subspecialty practice (valid for life)	10. 2–4-year subspecialty clinical training 11. Certification of completion of training 12. Malpractice insurance mandatory	8. Subspecialty clinical training in an accredited programme for at least a year 9. Exam for subspecialty board certification (validity period is variable) 10. State practice licence required to practice in the jurisdiction (1–2-year validity) 11. Malpractice insurance mandatory

[8] Requirements are for nationally trained medical doctors. The requirements for foreign-trained doctors may vary and are not included here.

[9] The contents of this table originated from tailored searches conducted by the WHO Secretariat in collaboration with national counterparts to illustrate the diversity of routes to entry to practice across countries.

3.3 Effects of health practitioner regulation on health services

Research studies reporting the impact of health practitioner regulation on population health are rare *(138)*. There was minimal reference in the studies included in the integrative review to an experimental or quasi-experimental design with a control group, which limited insights into effectiveness. However, the literature provides some evidence of the effect of health practitioner regulation on access, cost and quality of health services, on the international mobility of practitioners and on models of health practitioner education and delivery.

Access to health services. Some researchers have shown that regulatory mechanisms, such as licensing, increase labour supply into occupations, including historically under-represented groups *(139)*. There is evidence that regulatory interventions, such as the issuance of professional licences after completion of rural service, have improved the recruitment of health practitioners in rural and hard-to-reach areas *(140)*. Flexibility in regulating health practitioners with regard to scope of practice, education programmes and conditional licensing can expand access to primary care when these practitioners work in underserved areas *(95)*. Health practitioners who are allowed to practice to the full scope of their education can increase practitioner availability and public access to the services they offer. On the other hand, when the scope of practice is tightly defined and narrower than their expertise or prevents available practitioners from delivering services, inefficiencies may manifest as limited access to health services *(141, 142)*. Such artificial shortages of practitioners can occur when representatives of market participants (for example, professional associations and businesses) have a decision-making role in regulatory bodies *(43)*.

Cost of health services. While the integrative review did not identify evidence of the effect of regulation on the costs incurred or wages of practitioners, the scoping review and the TEG found that regulation involves costs to health practitioners (including education, registration and licensing fees), to governments (such as subsidizing practitioners' fees or granting tax relief) and to employers. This influences the cost of health services for the entire health system. When practitioners available to carry out specific functions or procedures are limited because of excessive restrictions on entry to practice and on scope of practice, this can increase the cost of health services while also increasing the wages of health practitioners *(143–148)*. However, there are also examples of regulatory interventions designed to improve patient safety without increasing the cost of health services for patients or decreasing service utilization *(149)*.

Quality of health services. Regulation is meant to set the minimum standards for practitioners' entry to a profession that contributes to the quality of health services. However, there is wide variation in the quality of regulated practitioners, raising questions about the standardization of health occupations *(44, 150)*. Studies in selected HICs suggest that less rigid regulation (concerning the scope of practice, licensing, etc.) does not change the quality of services *(62, 144, 151)*. Some HICs use the disciplinary data on health practitioners available from regulators to identify risk factors at the aggregate level that can be addressed through early interventions *(152–154)*. In addition, the TEG highlighted studies that also demonstrate that restricting the scope of practitioners on certain activities, such as ownership of pharmacies, can bring positive outcomes in relation to unnecessary drug prescriptions. However, practitioners can find other ways to advance their economic interests *(155, 156)*.

International migration and mobility. Regulatory processes influence the scale and speed of international migration and the mobility of health practitioners. Regulatory processes to integrate migrant health practitioners can enable countries to address health workforce shortages through foreign-trained health practitioners, including the quick deployment of practitioners during emergencies *(157, 158)*. Conversely, States with strict regulatory requirements are found to have less health practitioner immigration *(159)*. The requirements for foreign-trained medical graduates' entry into HIC graduate programmes have boosted the accreditation of educational institutions in some LMICs *(117)* in parallel with the increasing international mobility of health practitioners *(160)*. This demonstrates the dominant effect of some HIC standards. The international movement of a significant number of health practitioners from countries with weaker health systems can leave the health systems of source countries vulnerable, which exacerbates health inequities *(161–163)*.

Models of education and service delivery. Fragmented regulatory functions and excessive rigidities in reservation of practice can impede workforce optimization *(164)*. They can also be obstacles to implementing new and promising models of education and service delivery, such as interprofessional education, apprenticeship models of education, digital education, technology-assisted learning, telehealth, team-based care and multi-disciplinary practice.

3.4 Regulatory reforms and innovations

Regulatory reforms are systematically carried out to advance the public interest, the understanding of which evolves over time *(165)*. The contemporary interpretation of the public interest *(5, 25, 165)* prioritizes cost-effectiveness, competition, practitioner mobility, consumer choices, business interests and responsiveness to health system needs (Table 4).

While some countries have established systems of periodic review that identify the need for reform, others have undertaken regulatory reforms triggered by various factors. These factors include: regulatory failures to protect the public; maintaining a fit-for-purpose and sustainable health workforce; improving the quality of practitioners; meeting international or regional standards to promote mobility; addressing failures in the health labour market; ensuring the efficiency, transparency and accountability of regulators; and advancing health policy goals and lobbying by occupational interest groups *(125, 164, 166–171)*. Some of the reforms have been incremental and addressed specific issues or ongoing reform programmes. Others have overhauled the regulatory structure by replacing the status quo with an entirely new system.

Contemporary trends in regulatory reform

The direction of reforms is not the same across jurisdictions. Instead, it is often tailored to meet individual country needs.

In some countries, there is a tendency to progressively strengthen the external oversight and accountability requirements placed on regulators. Governance structures are revised to enable regulators to operate transparently and in a manner that reflects a more diverse range of interests beyond the practitioners. A shift from profession-led regulation to regulation with more government oversight (including replacing elected practitioners on regulators' governing boards with appointed members and greater inclusion of the public and representatives from the community and government) has mainly been reported in countries where traditionally the regulation of health practitioners has been led by the professions *(29, 30, 90)*. Conversely, countries with strong government-led regulation are increasing the role of professional associations in regulation *(132, 172)*.

In some Anglophone HICs, there is a trend towards umbrella statutes governing health practitioners from multiple occupations, rather than occupation-specific laws, to boost efficiency and coordination *(29, 164)*. Such umbrella laws are intended to address the inconsistencies that result from fragmented and occupation-specific regulation and allow coordinated functioning and efficient updating of the legislative framework. A single regulatory body, which has the structural and administrative arrangements for the occupation-specific input required for regulatory decision-making, can enable the sharing of resources. It also provides greater economies of scale compared to several practitioner-specific or function-specific regulators *(173–176)*.

Reforms have placed greater expectations on regulators for more transparency and accountability in operations and for procedural fairness towards registrants. Some countries have separated those responsible for the investigation and prosecution of

Table 4.

Understanding the public interest over time

Traditional perspective	Contemporary perspective
• Standards of practice • Standards of qualification • Elevating the profession • Addressing public information deficit • Entry barriers • Competence of practitioner • Access to services	• Alignment with health system needs • Costs of regulation • Increased efficiency • Increased cost effectiveness • Reduction in entry barriers • Reduction of barriers to mobility • Promoting competition • Regulation that is proportionate to risk • Promoting alternatives to a licensure model • Responsiveness to a highly complex health system • Uniformity in regulations

Source: adapted from *(5)*.

disciplinary matters from those judging and imposing sanctions, and they have established tribunals outside the purview of the regulator for disciplinary matters *(177, 178)*. In some jurisdictions, oversight mechanisms have been established for regulators, such as an independent review process, government regulatory management systems and scrutiny by multiple integrity agencies *(167, 179)*.

Boxes 1–4 illustrate the regulatory reforms in four countries. Each reform responds to the individual country's priorities and has been enabled by wide stakeholder engagement. Government leadership and engagement at the highest levels have been crucial in managing different groups' competing interests and removing barriers to accelerating the reform process. The country examples were identified by the scoping review and the TEG and were added by the WHO Secretariat in collaboration with national counterparts.

Box 1.

Establishment of a single national multidisciplinary health practitioner regulator in Australia

Before 2009, health practitioners in Australia were regulated by over 30 laws and 85 separate bodies across the eight jurisdictions, each with its own regulatory system. The reform was triggered by the Productivity Commission's recommendation to establish a single national registration board for health professionals and for health professional education and training. Extensive consultations took place with all jurisdictions and 10 health professions. In 2008, the Council of Australian Governments agreed on the structure of the scheme. The Queensland Parliament was the first to pass legislation establishing the National Registration and Accreditation Scheme and the structure of the Australian Health Practitioner Regulation Agency (Ahpra). Prior to this, consultation forums were held in all jurisdictions to allow practitioners and other parties to review the draft bill. The recommendations from the consultation were incorporated in the amended bill in the Queensland Parliament in 2009.

The Health Practitioner Regulation National Law Act (2009) was a landmark reform that replaced over 30 different legislations in Australia and established the Ahpra initially with 10 professional boards. The Agency's aim is to provide: public protection; facilitate workforce mobility, high quality education and assessment, and access to services; and enable development of a flexible and sustainable health workforce.

Ahpra adopted a right-touch approach in its regulatory principles. This approach is based on the likelihood of actual harm occurring to the public and aims to prevent wasting resources on areas where harm to the public and benefits from regulation are negligible. The national boards collaborate on matters of common interest and have a profession-specific focus on other issues. Health practitioners who are not registered with the professional boards are regulated through negative licensing in most jurisdictions. Moreover, the regulatory approach which regulates title allows registered practitioners to work to an expanded scope of practice based on training and competence. This facilitates interprofessional education and an efficient utilization of the workforce.

The regulatory reform also established uniform registration processes for all health practitioners across the country, acilitated practitioner mobility and improved public safety. Previously, practitioners had been able to move to another jurisdiction to potentially avoid scrutiny. The reform has also supported workforce planning as demonstrated during the COVID-19 pandemic response with the creation of a temporary pandemic registry to swiftly allow almost 40 000 retired practitioners to practice without any legislative changes, application forms or fee.

Sources: *(25, 39, 101)*.

Box 2.

Replacement of the Medical Council of India with the National Medical Commission

Before 2018, India's health practitioner regulation was structured on the pre-independence British model, with the Medical Council of India (MCI) and its state branches responsible for all the regulatory functions for medical education and practice. The Indian Medical Council Act, 1956, was amended in 1964, 1993, 2001 and 2019. MCI was a statutory body which consisted of elected doctors. Concerns were raised about conflict of interest in the regulatory body and the low-quality education and high fees charged by many private medical colleges.

Since 2008 various commissions, expert groups, Parliamentary Committees, and NITI Aayog, the erstwhile Planning Commission of the country, had recommended reform of the MCI. In 2018 the Parliament of India passed a regulatory reform undertaken under the leadership of the Prime Minister and in consultation with various stakeholders to improve access to quality medical education and promote universal health care. The National Medical Commission Act (2019) established the National Medical Commission (NMC), consisting of a government-appointed chairperson, a medical advisory council and four autonomous boards, to replace the MCI.

The NMC conducts a common national entrance exam for admission to a medical programme. It has mandated that, in each State, the fees for 50% of the seats in private medical colleges should be at par with the fees for the government colleges. The NMC maintains a national registry of medical professionals and rates medical colleges based on defined minimum standards. For primary health care services, the NMC has provisions for granting a licence to Community Health Providers for limited practice and prescription. It also streamlined the minimum requirements to encourage the establishment of new medical colleges in underserved areas. The expansion of the postgraduate courses promotes family medicine, and all postgraduate medical training programmes include postings to district hospitals and other public health facilities, increasing the participation of medical colleges in national programmes. The NMC is also introducing a common national final-year exit exam for MBBS, which will serve as the licensing examination and the entrance exam for postgraduate education to ensure common minimum standards among graduates, including international medical graduates. The Commission has also published the Professional Conduct of Registered Medical Practitioners Regulations, 2023, which contains practitioners' duties and responsibilities, rational prescription mandate and telemedicine, among others.

Similar reforms in the regulation of other health professions followed. In 2021, the National Commission for Allied and Healthcare Professions Act was introduced to establish a National Commission for Allied and Healthcare Profession to regulate more than 50 diverse allied health care professions. In 2023, the Parliament passed the National Nursing and Midwifery Commission Bill, 2023, to establish the National Nursing and Midwifery Commission to regulate the education and practice of nurses and midwives; and replaced the Dentists Act, 1948, with the National Dental Commission Bill, 2023, to establish the National Dental Commission to regulate the education and practice of dentists and dental auxiliaries.

Sources: *(168, 180–186)*.

Box 3.

Regulation to strengthen patient safety in Kenya

Before 2010, regulation in Kenya's health sector was centralized. It was mostly carried out by occupation-specific health professional bodies. However, there were calls to strengthen legislation to advance consumer interests. In 2010, the Constitution of Kenya explicitly articulated the right to health and devolved power to 47 local governments. In alignment with the new Constitution, the first major health legislation after independence, the Health Act, 2017, established stewardship bodies with greater focus on the public interest. Among other provisions, Kenya made indemnity coverage mandatory for all health practitioners and established the Kenya Health Professions Oversight Authority (KHPOA). The KHPOA maintains a duplicate register of all health professionals; promotes interprofessional liaison between the regulatory bodies; coordinates joint inspections with all regulatory bodies; arbitrates disputes among statutory health regulatory bodies; facilitates the resolution of complaints and grievances from patients, aggrieved parties and regulatory bodies; monitors the implementation of the mandates and functions of the different regulatory bodies; and ensures standards for health professionals are not compromised by regulatory bodies.

Health practitioner regulation in Kenya is carried out by nine independent agencies, each governing the practitioners of its respective discipline. Coordination among the regulators has facilitated positive outcomes in service delivery. From 2013 to 2020, the regulators worked together to create the Joint Health Inspection Checklist (JHIC) to determine patient safety standards at health facilities for the Kenya Patient Safety Impact Evaluation study (KePSIE). Following approval by the Cabinet of Ministers, the KePSIE was the first randomized controlled study to look at the impact of regulations and inspections in 1258 public and private health facilities serving 4.5 million people in three counties. It used a risk-based approach to determine the follow-up actions. The lowest scoring health facilities are re-inspected more regularly and given warning notices to ensure improvement before the next inspection. The KePSIE showed significant improvement in patient safety scores across both low- and high-quality facilities but more so in private health facilities. There was no increase in the out-of-pocket expenditure or decrease in service utilization. However, patients shifted from the private sector to the public sector in intervention facilities.

Following the success of the pilot, the Government of Kenya made compliance with the minimum requirements in the JHIC mandatory for registration, licensing and publication of all health facilities in an official gazette in 2020. The Joint Health Inspection Team also undertakes reactive inspections following complaints from the public or suspicions of noncompliance with minimum standards without warning to the health facility. Teams from relevant government programmes and any programme specific requirements may also be included in the inspections.

Sources: *(149, 179, 187, 188)*.

Box 4.

Launch of publicly funded standardized residency training for medical doctors in China

China has launched a new round of health system reforms since 2009. The aim is to invest substantially in expanding health infrastructure, achieve near-universal health insurance coverage, promote more equal access to public health services and establish a national essential medicine system for its 1.4 billion population. A Leading Group headed by the Vice Premier of the State Council and including more than 20 ministers was set up for Deepening Medical and Health System Reform to strengthen multisector coordination.

Until 2013, each province in China conducted medical residency training according to its own standards under the guidelines of the national health authority. The training provided in different hospitals was therefore not uniform. Furthermore, medical residents were mostly permanent employees of the hospital. This meant that a doctor working in a high-level hospital could receive better training to develop their professional skills and knowledge than those employed in other health facilities. This variation was also an indication of the quality of health services received by the population. In 2010, Shanghai province piloted a programme to provide an accreditation system to validate professional qualifications through peer-testing for its 300 hospitals. It also postponed the permanent employment of medical graduates to after they have completed their residency training.

Following the Shanghai pilot, the Government launched the publicly funded Standardized Residency Training (SRT) in December 2013, as part of its health system reform. This system aims to raise the standard of, and ensure consistency in, medical training throughout the country. The focus was on the development of clinicians rather than academics. The SRT guidelines detail the process in the "5 + 3" training model (five-year undergraduate medical education followed by three-year standardized residency training in 36 specialties). The training content and accreditation standards were developed by the Chinese Medical Doctor Association, under the direct governance of the national health authority. The SRT is provided in government-accredited institutions, such as tertiary hospitals. Since 2020, it has been mandatory for doctors to undergo SRT to be allowed to engage in clinical practice.

By 2017, more than 290 000 medical doctors had completed SRT, thereby playing an important role in progress towards the health targets for the "Healthy 2030" Blueprint. Meanwhile, other models of training for health practitioners are also being explored, including the "3 + 2" training models (three-year higher vocational clinical medical education followed by two-year assistant general practitioner training) for practitioners coming from the vocational diploma track.

Sources: *(132, 189, 190)*.

3.5 Experience from the COVID-19 pandemic

The coronavirus disease (COVID-19) pandemic and the physical-distancing policies put in place in response to it (including lockdowns or stay-at-home orders) hindered patients' direct access to health services. This highlighted the importance of agile regulatory processes and the necessity for health practitioner regulation to align with health system priorities. Governments responded by making a surge workforce available during the emergency period and pushing through various legislative and administrative changes in regulation at an unprecedented speed. Regulators with the authority to modify or adapt regulatory processes and mechanisms were able to swiftly respond to the emergency, while others had to adopt legislative amendments to allow regulators to make changes. Flexibilities in the scope of practice and division of labour enabled the utilization of the available workforce to address emergency needs *(191)*.

In contexts where health practitioner regulation is independent of or has some autonomy from the government, the pandemic presented opportunities for governments and regulators to work together to respond to the emergency and innovate. This suggests positive opportunities for longer term reform. For instance, regulators created temporary registries specifically to enable the additional workforce required for the pandemic response. They also introduced flexibilities and modified requirements on education programmes, entry to practice, scope of practice, telehealth provisions and the portability of international qualifications or licensure.

Regulators also adapted their operational processes during the emergency. These modifications included paperless administration, waivers or relaxations of administrative requirements and increasing compliance, and greater use of virtual platforms for engagement.

Flexibility measures adopted by regulators included:

- changes to teaching methods, with greater use of virtual and simulation learning platforms, changes in graduation requirements, and the use of students in the workforce *(192, 193)*;
- streamlining entry and re-entry to practice processes, particularly for medical practitioners, nurses and other retired practitioners *(25, 194)*;
- ensuring the validity of practitioner licences across subnational and national borders to facilitate mobility *(25, 191)*;
- enabling more flexible scopes of practice, expanding advanced practice roles and providing greater flexibility in roles and the performance of specific tasks *(25)*;
- minimizing regulatory barriers to allow service delivery through telehealth *(25, 191)*;
- fast-tracking the recognition of foreign qualifications and minimizing regulatory requirements for international health practitioners *(193, 195)*;
- decongesting health facilities through longer drug prescription dispensing periods *(196)*;
- extending regulatory mechanisms to address the "infodemic" of misinformation on COVID-19 and vaccines from nonregistered practitioners *(197)*;
- shortening the regulatory impact assessment processes to make regulatory policy decisions during emergencies *(198, 199)*; and
- reducing or modifying operational processes and requirements for revalidation to reduce regulatory burdens on registrants *(194)*.

The pandemic also demonstrated the need for reliable data on available practitioners and skill profiles to plan for emergency deployment and increase surge capacity. While some regulators were quickly able to develop temporary pandemic registers for surge support, others did not have adequate information on the available practitioners, their distribution and skill profile, which hindered an efficient response *(26)*.

The important role of different types of health practitioners in health service delivery was also apparent. The roles of associate professionals and health assistants in HICs were expanded to relieve the burden on health professionals engaged in the emergency response and to facilitate new forms of service delivery (for example, virtual care) (200). The TEG highlighted that in LMICs existing laws permitted the rapid training and deployment of practitioners in various health occupations, including community health workers and informal practitioners, for the COVID-19 response. Their tasks included disease surveillance, risk communication, referrals and vaccinations, which also contributed to the successful vaccination of more than a billion people in a short period of time *(201–204)*. In some places, governments used trained practitioners of TCIM in COVID-19 care clinics and administration of vaccines *(203, 205)*.

The pandemic experience has contributed to long-term regulatory changes in some countries, especially with regards to graduation requirements, skills assessment and telehealth *(206–208)*. In others, the regulatory flexibilities ended with the cessation of the emergency. In some jurisdictions, legislative changes enabling the expansion of scope of practice have been legally challenged and defeated *(209)*. Evaluating the effectiveness of regulatory flexibilities during the pandemic, including the operational and decision-making processes, can provide valuable evidence in preparing for future emergencies. It can also inform

regulatory reform, thereby enabling regulators to determine regulatory mechanisms and processes that balance the risk to the public with access to health services within the available resources *(192)*.

3.6 Challenges particularly relevant in low- and middle-income countries

While countries at all levels of socioeconomic development face regulatory challenges to varying degrees, some issues are more prominent in LMICs where most of the world's population live and face the bulk of the global burden of disease *(210)*. In addition, a large proportion of health practitioners from LMICs move to another country during their professional lives. As a result, health practitioner regulators in LMICs are under pressure to tailor regulatory standards and processes to both local and international needs, which may be substantially different and risk diluting the focus on local priorities.

Regulation-strengthening activities in LMICs that have been financed by development partners can deliver positive results when they are responsive to local contextual needs *(74, 211, 212)*. However, donor-funded activities can have conceptual biases. These include promoting profession-led or siloed governance models for delivering accreditation functions for health practitioner education and promoting the use of health practitioner regulation to define and control individual scopes of practice *(26)*. Of particular concern is the risk that core regulatory functions and requirements might be unduly influenced by objectives related to international mobility and the migration of health practitioners, rather than respond to local population needs.

The effectiveness of health practitioner regulatory systems is generally influenced by the strength and type of governance, education, health and legal systems, health practitioner availability and coordination between stakeholders. Regulatory goals may not be met because of systemic factors and shortcomings in the design or implementation of regulation *(213)*. In LMICs, additional factors may hinder the functionality of regulatory systems: the institutional structure and regulatory mechanisms inherited from colonial history or imported into the country without due consideration to the local context; and the capacity of regulators in relation to the growth of educational institutions and practitioners *(18, 75, 76, 86–88, 214, 215)*.

Further causes of regulatory failures that are particularly prominent in LMICs may include: uneven enforcement capacity and inadequate organizational frameworks for regulation; corruption and lack of transparency and accountability within regulatory organizations; discrepancies between the putative functions of regulatory organizations and the roles they actually perform; low political will for regulation and the "capture" of regulatory institutions by vested interests; and information asymmetries and unequal power relationships between health practitioners and users *(19, 86, 87, 125)*. Although these challenges are not unique to LMICs, they may be more acute and have deeper ramifications in some of these contexts, with negative implications for health equity.

Three areas of concern were identified by the scoping review and the TEG that warrant particular attention.

- **Variation in standards.** There is wide variation in knowledge among regulated health practitioners and the quality of health advice and services provided, within and between countries. This is particularly acute among practitioners serving poor and rural populations and between public and private practice *(44, 150, 216, 217)*. Regulatory systems are not the only factor determining the performance of health practitioners. However, in many contexts they appear inadequate to assure the minimum standards of health practitioners who serve the most vulnerable segments of society *(218)*. Such shortcomings can in turn worsen health inequalities.

- **Informal health practitioners.** Uncertified health practitioners are prevalent in many LMICs and provide primary care to a significant proportion of the population, despite the lack of legal recognition *(44, 219, 220)*. The knowledge of these informal health practitioners varies widely, as does the range of health services they provide in allopathic and TCIM, especially where available alternatives for the public may be limited. The training of informal health practitioners has led to a demonstrable improvement in the quality of care in some places *(221)*. Nevertheless, in communities where informal practitioners are the only providers of health services, it remains a challenge to create longer term interventions to ensure patient safety and establish a formal link with the health system.

- **Short-term international practitioners.** The use of short-term international health volunteers in settings with unmet needs for health services and limited capacity for regulation enforcement can create risks. These include incidents of patient harm and the opportunity to escape investigation, disciplinary action and liability. There have been many reports of patient harm in such contexts *(222–224)*. Yet there is little evidence of effective mechanisms to hold health practitioners accountable for incompetence, malpractice or misconduct outside of the jurisdictions or countries in which they are registered. This suggests that regulators may need stronger powers or

measures to deal with instances of deviation from standards and misconduct that occur outside their geographical boundaries or relate to practitioners licensed and located in another jurisdiction.

3.7 The regulatory practice gap

The establishment of regulatory systems and the setting of high standards for health practitioners does not necessarily translate into practice. The term "regulatory practice gap" was coined by the TEG to highlight the implementation gaps of existing regulatory policies. The evidence for this section was identified by the TEG and the scoping review. The regulatory practice gap is the difference between regulatory policy and regulation in practice: policy may not be implemented or, where it is, it may not achieve its intended purpose. The regulatory practice gap may occur because of over-regulation, under-regulation, inappropriate policies or operational issues.

The existence of this gap in countries with mature regulatory systems has been demonstrated by failures to ensure patient safety caused by deficiencies at different levels *(167, 225–228)*. In LMICs, fulfilling regulatory requirements for entering or practising a profession may not always be a sufficient indication of minimum standards and, conversely, some regulatory laws and standards may even be impossible to enforce *(44)*. In some contexts, less than half of working medical doctors may comply with registration requirements *(75)* and only half of those registered may be in active practice *(229)*. The proliferation of substandard private sector education remains a concern *(14, 230)*. Furthermore, the prevalence of a large "know–do gap" among health practitioners in several countries suggests that qualification, which is often the main criterion to determine standards for entry, cannot in itself guarantee a practitioner's quality *(231–233)*.

Main drivers of the gap between regulation on paper and regulation on the ground

Although the divergence between policy and practice is not unique to regulation, large regulatory practice gaps indicate regulatory failure, with implications for the public's trust in regulatory systems, regulators and practitioners. Some of the common reasons behind the regulatory practice gap are presented below.

(1) **Lack of contextual suitability.** Regulation does not work in isolation. The variations in human population and culture, health systems and service delivery profile, political economies and structures, education and legal systems, institutional structures, practice environments and governance, all influence the design, purpose and functionality of practitioner regulation. Although crucial, social and environmental contexts are sometimes ignored in the design of regulatory systems. Instead of tailoring the design to meet local economic and political realities, regulatory systems often follow models inherited from colonial history or imported from other substantially different settings *(18, 234)*. Furthermore, when health practitioner regulation is disconnected from service delivery, the standards determined by the health practitioner regulator may not match the environments in which services are provided.

While regulatory objectives may be set with good intentions, the health priorities of the public, particularly underserved and vulnerable groups, may be overlooked when the regulatory mechanisms, processes and standards are determined. These targets may be unrealistic or only achievable in certain sections of the jurisdiction or society, or they may fail to deliver expected results altogether. Furthermore, when regulatory systems are fragmented, the standards set by regulators of different professions for the same risk profile in the same setting can be inconsistent. Sometimes regulators may even interpret their legislation and standards to protect themselves rather than to facilitate service delivery and public protection.

(2) **Primacy of logical assumptions over evidence**
The design of regulation is often based on the theoretical assumption that regulatory standards, processes and requirements (input) will deliver the minimum standards of health practitioners (expected output), which in turn will lead to patient safety (desired outcome). Validation of these assumptions by scientific and context-specific evidence is extremely rare. Furthermore, health practitioners use their own judgement to make decisions, and, although regulatory standards can help to guide these judgements, they are not determinative in each case. Without testing or evaluating the strengths and limitations of a regulatory model (and mechanism) in the local context, it may be difficult to check for the degree of enforceability, plan resource requirements and address unintended consequences.

Increasingly, occupations are regulated across countries at different levels of economic development. Yet, the decision to regulate is rarely based on objective criteria. Regulation is not useful if it does not yield improved patient outcomes. Also, the evidence on the practical results of regulation is limited. However,

frameworks have been adopted in different countries to evaluate progress in strengthening health practitioner regulation *(235, 236)*. These frameworks measure activities and outputs (for example, registrants or educational institutions that meet regulatory standards or face disciplinary action), but measurement of actual outcome (patient safety) and impact (population health) is rarer and inherently more difficult. This is because health practitioner regulation is only one of several contributory components. The outcome measurement may, therefore, be beyond the unique purview of regulators.

(3) **Overburdened and under-resourced regulator.** A common reason for the regulatory gap, especially in LMICs, is the resource limitation of the regulatory body *(87)*. To deliver results, the capacity of regulators should be proportional to their assigned functions and responsibilities. Some regulatory entities that are responsible for the education and/or practice of thousands of practitioners have few full-time staff and scant infrastructure, technology, logistics and financial resources. It is unrealistic to expect them to achieve ideal standards adapted from another context and to coordinate with other entities. Furthermore, health practitioner regulation is used to support an expanding set of priorities.

This may add additional burdens to already overstretched regulators who are struggling to effectively perform their primary functions. As a result, practitioner compliance with regulatory policies can be variable. Weak implementation also worsens revenue collection for the regulator.
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(4) **Strength of governance.** The accountability structure, the level of transparency of regulatory operations and decisions, and power differences between different stakeholder groups (such as businesses, employers, the government, practitioners and the public) influence the design of regulatory systems and the way regulation is enforced. The effect of regulation on the health labour market and the growing international demand for health practitioners can also make it a tool for advancing the interests of different stakeholder groups, such as professional associations, employers and businesses *(43, 86, 87)*.

Chapter 4

The process to assess and minimize the regulatory practice gap

This chapter outlines key steps countries can consider when introducing, evaluating or updating their regulation for health practitioners. It emphasizes the importance of understanding the primary problem to be solved and the purpose and expected outcomes of regulation before focusing on its design and operating structure. There is no blueprint for health practitioner regulation that has universal applicability. Instead, health systems have complexities and considerable differences, with services being delivered by different health occupations with distinct and context specific roles. Accordingly, optimal regulatory intervention will not be the same across health occupations, communities and health service delivery systems.

The foundation of an effective approach towards meeting regulatory goals is to understand the local context, including the social, cultural, economic and population health needs, the health system's capacity, workforce capability and public expectations. Before considering the structure of regulatory systems, it is necessary to identify the risk level of patient harm from health practitioners in the local context and within existing systems, gauge available measures to address it and determine the regulatory practice gap.

Based on the consensus of the TEG, we propose an eight-step process (adapted from the Right-touch regulation principles) to assess the regulatory practice gap and reduce risk of patient harm. Table 5 lists the guiding questions in each step to tailor the approach to the local context.

Step 1: Understand the social and environmental context.
Careful review of existing systems is the first step to understanding the context in which regulation is expected to function. This includes: the objectives and functions of existing regulatory bodies in relation to the broader political, social and economic context; the health system structure and service delivery standards; the regulatory system's linkage to health, education and legal systems; the institutional capacity (including the number of staff and their qualifications), authority and processes, infrastructure, technology and logistics, financial resources and support (such as the availability of university courses or training opportunities on regulation and incentives for regulators); the size and distribution of the workforce to be regulated and their practice environment; population characteristics; and public expectations. The perception of the role and competence of health practitioners in different contexts may not always align with the international classification of occupations, which makes it important to understand the social factors that influence the public's understanding of health, healing, patient harm and health practitioners.

Step 2: Identify the problem.
After understanding the context in which regulation is expected to function, it is important to conduct a gap analysis. This includes studies to analyse the extent to which the implementation of regulation corresponds to the regulatory policy and the extent to which policies and practices serve the regulatory purpose and meet public expectations.

The design of these studies varies according to the priority issues to be addressed and their feasibility in the specific context. A standardized survey among practitioners, such as the Service Provision Assessment *(237)*, World Bank Service Delivery Indicators *(238)* or national minimum service standards assessment, can be used for alignment with national standards.

Other methods include, but are not limited to: the pass rate in licensing or exit examinations; a survey of practitioners fulfilling a checklist of requirements on knowledge and/or practice, based on regulatory or government-recommended standards presumed to be necessary for patient safety; knowledge assessment through clinical vignettes; practice assessments using standardized patients; data on, for example, patient outcomes, hospital stays, diagnosis and prescriptions, mortality and morbidity; the number of complaints and cases of malpractice *(149, 153, 216, 217, 239)*. The findings can be checked for consistency with data available from regulators or administrators.

Once the findings have been documented, a structured interaction with regulators, practitioners, civil society and relevant officials can identify the root causes of the gaps, for example: design faults in the regulatory model; inappropriate regulatory mechanisms; inadequate or overambitious regulatory standards; capacity limitation within the regulatory body; and subnational inequities.

If no gaps exist, there is no need to develop new regulatory interventions.

Step 3: Determine the outcome.

The findings from the situational analysis, operations research and stakeholder consultation enable targeted discussions on defining actual patient or user harm *(2)*, the desired (regulatory) outcome in the specific context and how it could be achieved. Since regulation is only one of several factors that influence patient safety, it is crucial to decide whether the existing arrangements are sufficient or whether new models will be necessary to achieve the targeted outcomes. Adequate stakeholder consultation (with, for example, government/health authorities, patient/public representatives, practitioners, regulators and employers) is crucial to understand the different perspectives and expectations, share evidence and identify common priorities.

Step 4: Assess the risk of harm (adapted from Right-touch assurance methodology *(240)*)

Before thinking about the regulatory mechanism or structure, it is crucial to first understand the hazards[10] and factors that increase and decrease the risk[11] of harm *(2)* from the tasks performed by practitioners in a specific context. According to the Right-touch-regulatory principles, risk assessment is a two-stage process *(240)*.

The first stage creates a risk profile of an occupation, based on its intrinsic risks of harm. Hazards associated with the work of health practitioners can be categorized into (i) complexity of intervention (the danger presented by the activity or task performed by the practitioner, such as harm from diagnosis, evaluation, surgical or medical interventions, practitioner actions or misconduct); (ii) the environment in which the intervention takes place (such as harm from lack of clinical governance, supervision or support); and (iii) patient/user vulnerability (due to the difference in power between the patient/user and practitioner). Based on the evidence of hazards and a judgement on the likelihood and severity of harm, a risk score could be allocated to each category of hazard and occupation.

The second stage applies extrinsic factors to assess the level of intervention required to manage the risk. It considers the scale of the risk and the severity of actual and/or probable harm, by quantifying the existing and projected size of the health practitioner group, the number of patients or service users, and the instances and severity of harm occurring.

Step 5: Deliberate on intervention options.

The findings from the earlier four steps provide information on the extent of the regulatory gap, the reasons for the gap, and the implementation capacity of regulators. This can quantify the actual risk of harm presented by a health occupation in a specific context. Such quantification will allow consultations among relevant stakeholders on options to reduce the risk. If nonregulatory interventions can address the gap or if existing mechanisms are satisfactory, then no change in regulation is necessary.

When regulation is necessary to manage the risk to patient safety, the chosen regulatory measure should be proportionate to the risk presented, and the benefit should outweigh the cost (to the public, practitioners, government and regulators). While high standards for entry to practice may be desirable, they can negatively

[10] Hazard is "a circumstance, agent or action with the potential to cause harm."
[11] Risk is "the probability that an incident will occur resulting in harm to a patient".

affect access to health services, especially for the most vulnerable population, and have consequences for health equity.

Depending on the context, the intervention required could range from incremental changes in regulatory standards, processes or the regulatory mechanism to an overhaul of the entire regulatory system. For each option, it is important to consider the probable impact on health service delivery, such as health workforce availability and distribution, the quality of practitioners, service costs, innovation, and the effect on the public and employers. Examples of some illustrative options for health practitioner regulation that can be used alone or in combination to minimize the likelihood of patient harm are presented in Table 6.

Step 6: Develop and test (improved) regulatory intervention.

If possible, any new regulatory standard or mechanism should be piloted and tested for efficacy. If not, operational research could be conducted during implementation to check for feasibility which would include: the ability to deliver results in a specific setting; identifying and addressing implementation challenges and possible unintended consequences (such as practitioner distribution, service accessibility, utilization and cost, and out-of-pocket expenditure, particularly for underserved populations) and resource requirements; and assessment of the effect on patient outcomes compared to the existing circumstances or alternative interventions, including nonregulatory measures. This kind of evidence-based approach would also help to plan for scaling up the intervention and generate consensus among stakeholders which may have different and often conflicting interests (for instance, governments, regulators, practitioners, the public and employers).

Table 5.

Eight-step process to assess and minimize the regulatory practice gap

Steps	Guiding questions	Possible methods
1. Understand the social and environmental context	• How are the existing regulatory systems aligned with the: (1) broader political, cultural and economic context; (2) health system structure and capacity; (3) education and service delivery standards; (4) population health needs and public expectations; (5) capacity to deliver its functions; (6) perceptions of patient/user harm?	Scoping review Stakeholder consultation
2. Identify the problem	• What is the extent to which: (1) the existing regulatory policy is implemented in practice; (2) the existing regulatory policy and practices serve their stated purpose and meet public expectations? • Why does the regulatory gap exist: o resources and capacity issues o regulatory model and mechanism o regulatory standards and process o regulatory policy objectives o others? ***If no gap is identified, there is no need to develop new regulatory interventions***	Specialized surveys (for example, World Bank Service Delivery Indicators, Service Provision Assessment, national minimum service standard assessment) Operations research Stakeholder consultation (regulators, practitioners, the public, employers, government, providers of health profession education)
3. Determine the outcome	• What is the desired outcome for beneficiaries in the specific context? • What is patient/user harm in the specific context?	Stakeholder consultation (regulators, practitioners, the public, government)

CONTD. **Table 5.**

Eight-step process to assess and minimize the regulatory practice gap

Steps	Guiding questions	Possible methods
4. Assess the risk of harm	• What is the likelihood of harm to the patients/users from specific tasks or health practitioners: o how complex is the intervention delivered by the practitioner; o what is the context in which the intervention is delivered by the practitioner; o how vulnerable is the patient/user? • What is the scale of the risk: o size of occupation o number of patients/users o instances of actual and/or probable harm o severity of the actual and/or probable harm?	Analytical research Stakeholder consultation (government, regulators, policy analysts)
5. Deliberate on intervention options	• What options (regulatory, nonregulatory) are available to minimize the risk? • Does the gap between desired outcome and existing system performance require any change in regulation? • What could be the impact of regulatory options on health workforce availability and distribution, the quality of practitioners, cost of services, and innovation? • What will be the effect of the regulatory option on the public, employers, etc.? • Do the benefits of the chosen option outweigh the costs?	Analytical research Stakeholder consultation (government, regulators, policy analysts)
6. Develop and test (improved) regulatory intervention	• Is the regulatory model/mechanism/standard feasible? • What are the unintended or unforeseen consequences of the intervention? • What, if any, adjustments are required to be scalable?	Pilot (if feasible) Operations research or implementation research
7. Manage capacity requirements	• What institutional requirements would be required to operationalize the regulatory option? • How can the necessary resources be allocated?	Operations research and analysis Stakeholder consultation (government, regulators)
8. Monitoring and evaluation	• What has been the impact of regulation on patient safety and health service delivery? • Is the performance of the regulatory system meeting public expectations? • Is the regulatory system efficient?	Measurement of difference in clinical practice; adverse events; complaints against practitioners; health practitioner availability and distribution; essential service coverage, etc. Stakeholder consultation (the public, practitioners, government, employers, educational institutions, regulators)

Step 7: Manage capacity requirements.

The institutional capacity of the regulatory body should be proportional to its functions. The findings of the pilot or evaluation from Step 6 will inform any adjustments to be made and the estimation of the resources required, including financial and human resources, infrastructure, technology and other logistics *(241)*. Governments should ensure adequate resources to sustain regulatory operations and to build the capacity of regulators, in line with the projected changes in the size and type of workforce to be regulated.

Step 8: Monitoring and evaluation.

Depending on the governance mechanism, regulators should periodically report on their specific performance metrics to the responsible entity in their respective jurisdiction. These reports could also be disseminated to all key stakeholders and made accessible to the public for transparency. Periodic review of health practitioner regulation is also important to assess its efficiency, its outcome on health service delivery and patient safety, and its impact on population health, including whether public expectations of regulation are met. Such evaluations help to improve programmes and identify any need for reform.

Table 6.

Options to minimize likelihood of patient/user harm[a]

Regulatory options	There are requirements for entry to practice	The minimum standards of practice are defined	There are requirements to maintain practice	Practitioners can be subject to disciplinary action	Expected resource requirements
Licensing	Yes	Yes	Yes	Yes	High
Mandatory registration	Yes	Yes	Yes	Yes	High
Certification	No	No	Maybe	Maybe	Medium
Mandatory insurance	No	Yes	Maybe	Yes	Medium
Inspection	Maybe	Yes	Maybe	Yes	Medium
Employer responsibility	No	Yes	Maybe	No	Minimal
Negative licensing	No	Yes	No	Yes	Minimal
Quality disclosure	No	Maybe	No	No	Minimal
Voluntary registry	No	Yes	No	Maybe	Minimal

[a] Given local variations in how different mechanisms operate, all features may not apply.

Chapter 5

Key policy considerations in the design, reform and implementation of health practitioner regulation

This chapter provides the core policy considerations and common principles to inform the design, reform and implementation of health practitioner regulation. They are grouped into four categories:

(1) design of the regulatory system
(2) institutional structure and governance
(3) core functions of the regulatory body
(4) supporting health system priorities.

There is a diversity of contexts, population health needs, health systems, health practitioners, and economic realities across countries. Therefore, the policy considerations presented here should be adapted to local specificities and targeted to meet regulatory objectives that are specific to each health system.

The needs of health systems are complex, variable and constantly expanding. These systems, as well as the health workforce, are stretched and tested by many factors, including population ageing, the increasing burden of noncommunicable diseases, evolving patterns of infectious diseases, the health consequences of climate change and antimicrobial resistance, new diseases and unforeseen emergencies. The processes and models of health service delivery will need to adapt and innovate, particularly in settings where resources are constrained.

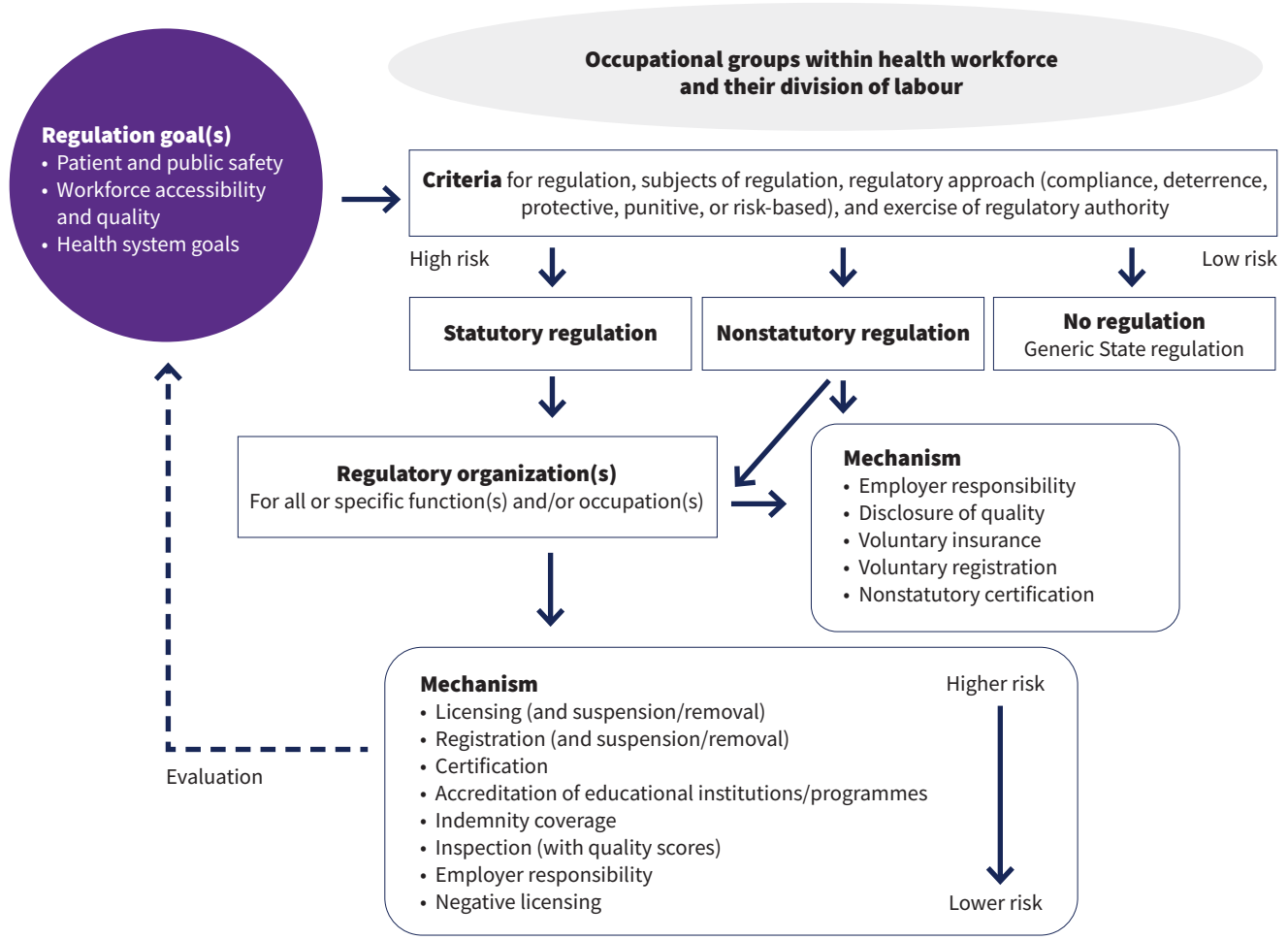
At the same time, technological advances have increasingly made it possible to deliver remote services via telehealth. This trend accelerated during the COVID-19 pandemic response *(242)*. The digital transformation and future developments in technology might alter the service delivery profile for some health practitioners. They might also introduce new health practitioners for health service delivery, including nonhuman ones (that is automated and enabled for artificial intelligence).

Keeping the focus on public welfare will, therefore, require dynamic and effective health practitioner regulation. Regulation should respond to changing health system priorities and keep pace with advances in technology and expectations. Effective health practitioner regulation may require action across the whole working lifespan of practitioners. Such action would include targeted and interconnected interventions at different junctures.

Fig. 5 presents a conceptual framework summarizing regulatory systems for health practitioners.

Fig. 5.

Health practitioner regulation: a conceptual framework



The evidence for actual results of different regulatory systems, processes and tools on patient outcomes is inconclusive because the design of current empirical studies does not allow for the establishment of causal linkages.

It is well recognized that the quality of health services and patient safety are a result of multiple factors. Regulation is important in determining the minimal competence that health practitioners need to contribute to patient safety.

All the policy considerations presented below have been developed based on the findings of the literature review and consensus among the TEG. In some cases, there are specific actions for government and regulators to consider, even if they are of a conditional nature and highly context specific. In other areas, the TEG preferred to only highlight issues for policy-makers to consider in the design and implementation of regulation. For all these reasons, on the whole, we refer to this section as "policy considerations" rather than "policy recommendations".

The generalizability and applicability of the considerations across different settings may be limited owing to a concentration of evidence from HICs. Although the policy considerations predominantly focus on regulatory systems centred on licensing schemes, the principles could be adapted to other contexts, as appropriate. If the risks to patient safety and regulatory gaps can be addressed without all the elements presented below, a different approach to regulation is also justified.

Regulatory systems should be designed to benefit population health

1. Purpose and principles

The purpose of health practitioner regulation should be to serve and protect the public, which includes promoting patient safety, and to advance health system goals.

The health and well-being of its population is a universal goal of every country or jurisdiction. The key purpose of health practitioner regulation should be to protect the public from harm by assuring the competence of health workers and defining the minimum standards of the services they provide. Health practitioner regulation should also facilitate progress towards achieving broader health system objectives, such as improving the accessibility, acceptability, availability and quality of health services. The focus is therefore on patient safety and improving patient health outcomes, through correct diagnosis and intervention from the practitioner *(29, 31, 243)*.

Among the main principles informing the regulatory scheme's design and delivery are regulatory accountability, agility and proportionality. The public's expectations concerning regulation should be met. The principle of "do no harm" is applicable to the regulation of all practitioners. However, considering the diversity of health practitioners and patient and user characteristics, health practitioner regulation needs to be designed to be proportionate to the risks of harm, to the benefits of the regulatory intervention, and to the regulatory burden imposed. It should also be responsive to population health needs and the changing demands that these place on the health system *(5, 25)*.

Although health practitioner associations and regulators share the objective of serving the public, their main purpose and primary beneficiaries are different *(34, 72, 244)*. Regulators are responsible for ensuring that practitioners deliver safe services and for enabling the public to make an informed choice about practitioners. In contrast, the primary role of professional associations is to advance practitioners' interests.

When regulators represent market participants, they can prevent other practitioners from carrying out certain tasks simply to restrict competition *(43)*. A functional separation of the two roles (in other words, regulating practitioners and representing their interests) is, therefore, essential to avoid a conflict of interests or the possibility of regulatory capture *(4, 177, 245–247)*. It is equally important for regulators to have clarity on their roles so as to prevent the professions or any other stakeholder group from gaining disproportionate influence and to maintain public trust in the regulators *(34)*. Considering the competition among different occupational groups in the market, regulators should maintain their primary focus on upholding patient safety.

2. Proportionality of regulation

Determine the regulatory mechanism for all health practitioners (including TCIM practitioners) based on their risk profile, composition of the health workforce and its division of roles, population health needs, and health workforce strategic priorities.

Health practitioner regulation is only one of the levers of patient safety and only one of several quality assurance mechanisms in the health sector. It can neither prevent nor protect against every adverse event, nor is it a replacement for effective employment practice and clinical governance *(111, 240, 248)*. Employers, practitioners and the patients themselves also play a role alongside regulators in minimizing the risk of harm. The extent to which these different elements contribute to risk reduction depends on the specific context and an understanding of the actual and perceived risk of harm.

The decision on which health practitioners (including new occupational groups) should be regulated should follow transparent and objective criteria that are relevant to the specific context. As described in Chapter 4, it is necessary, first, to identify the specific problem for the public that needs to be addressed; secondly, to consider the desired outcomes; and

finally, to determine the benefit to the public that can be practically achieved through regulation and other interventions. Risk assessment should include an appraisal of potential harms, actual harms and perceptions of harms within specific cultures to determine an acceptable level of risk posed by health practitioners that requires regulatory intervention. In deciding whether to introduce regulatory measures, the following elements should also be considered: existing or potential alternative means of quality assurance; the proposed measures' impact on the market, practitioner availability, quality and cost of services, and room for innovation; their expected benefits, including the effect on public and employer confidence; and any unintended consequences. The most appropriate way to regulate a specific health occupation in a given jurisdiction should be informed by a risk assessment, the desired output in alignment with standards of service delivery, context-specific evidence, the expected impact of regulation and the costs of and capacity for enforcement *(36, 111, 240, 248–250)*.

A "whole of health workforce" approach is required to decide on regulatory mechanisms and standards that are appropriate for the different health practitioner groups. If the public has enough knowledge on the subject to make an informed choice of practitioner and intervention, and this carries a lower level of risk, then less restrictive regulation or alternative risk reduction measures could provide sufficient protection. However, this is rarely the case in some categories of health practitioners and the services that they render, given the widespread asymmetry of information characterizing the health sector, as well as the high potential for harm from the interventions. Health practitioners presenting a minimal risk to public safety would require the least intensive regulatory mechanism (see Table 4). When the interventions provided by the practitioner are complex and present a higher possibility of harm, more stringent measures would be required for public protection. The most restrictive regulatory mechanism (that is, licensing) might be extended to additional health practitioners when it is proportionate to the risk of patient harm from the practitioners and population health benefits from licensing. More stringent regulation may also be essential in contexts where profit-driven market influences are strong, as compared to contexts where education and health service delivery are provided entirely by the public sector. The same principles apply for practitioners of traditional, complementary and integrative medicine (Box 5).

The public health workforce presents a different kind of risk from health practitioners providing individual patient care. So do occupations working independently or in isolation compared to those working under supervision, in team-based practice and under employer responsibility. Where available, information on the risk profile of occupations can be gathered from data analysis of service use, complaints/adverse events, availability of health services and health outcomes in relation to the context (for example, practitioner education, supervision arrangement, practice setting, treatment protocol, scope of practice, cost of health services and population characteristics).

Patient outcomes should be monitored to ensure the most appropriate regulatory mechanism is applied to achieve the regulatory objective. The risk profile of health practitioners and the health interventions may change over time and require updates and customization. Ultimately, regulation should not be more burdensome than necessary, it should avoid overlapping processes, and its benefit to the public should outweigh the costs.

Box 5.

Consider extending licensing to established TCIM practitioners, where warranted on patient safety or user safety grounds

TCIM practitioners play a substantial role in primary health care delivery, especially in LMICs *(65)*. Although the same regulatory principles may apply to all health practitioners, the regulation of TCIM practitioners requires additional considerations and innovative approaches. This is to ensure their competence in appropriately using indigenous therapeutic approaches.

The assessment of risk profile and public health benefits from regulation, a deliberation on the mechanism of regulation for the education and practice of different TCIM practitioners, and the position of regulators on scope of practice should follow the same principles as those applied to practitioners of allopathic medicine. TCIM practitioners cannot be considered a single group of health practitioners with the same risk profile, given the substantial differences in TCIM, including curricula and models of education, service delivery profile, standards for practice and division of labour *(65)*.

The decision on whether to regulate and on the regulatory mechanism and standards for each type of TCIM practitioner should be informed by the following factors: health system objectives; risk profile; and assessment of the regulatory practice gap (as described in Chapter 4) in alignment with the respective jurisdiction's TCIM policy *(251)*. Decisions on regulation should also reflect social norms and cultural values in the specific context. These vary in different settings. In some cases, TCIM regulation can raise concerns about equity, diversity and human rights. Uniform minimum standards of practitioners can be assured by standardizing education based on traditional knowledge as well as setting requirements for qualifying and entering practice for specific TCIM occupations, where applicable. However, the definition of such standards, and any decision regarding entry to practice for practitioners or the incorporation of certain practices from one type of medicine to another, need to be based on sufficient expertise of the subject and on adequate stakeholder consultation.

Meanwhile, considering the weaker position of TCIM compared to the dominant stream of medicine in most countries, it is essential to build the capacity of the regulatory authority and TCIM expertise to further public protection *(66, 69, 70, 72)*.

3. Flexibility in emergencies

Regulatory schemes should be able to rapidly adapt to health emergencies by introducing regulatory flexibilities without compromising patient safety.

Health crises and humanitarian emergencies may urgently require additional health practitioner respondents. However, the delivery of essential health services should not be compromised. In such situations, regulators can play an important role in helping to rapidly mobilize additional practitioners or in utilizing existing ones to provide surge support without compromising patient safety *(192, 252–256)*. Flexible legislative tools are necessary for regulators to enable swift regulatory action when needed. Regulators should have sufficient discretionary powers to facilitate access to health services during emergencies. They should also have a business continuity plan so that essential activities remain functional during unexpected events and emergencies.

Emergencies may present an opportunity for piloting new regulatory strategies and for evaluating their impact on patient outcomes. Temporary regulatory arrangements can generate evidence to inform the more effective and efficient updating of regulatory systems in the future *(199, 257–261)*.

Regulatory actions to rapidly increase the availability of health practitioners during emergencies could include *(26, 162, 192, 193, 195, 257)*:

- temporary relaxation of certain regulatory requirements, accompanied by appropriate controls to prevent patient harm
- modification of essential administrative arrangements (such as streamlined procedures, relaxed administrative rules and inspection regimens, and flexibilities in requirements for the maintenance of competence)
- increased use of digital technologies
- streamlining of registration requirements
- fast-tracking of qualification recognition and portability of licensure across borders
- arrangements to communicate government advice/protocols for diagnosis, treatment and referrals
- specifying emergency registration requirements, processes and scope of practice for new practitioners or international practitioners
- specifying malpractice liabilities during the emergency.

In contexts where health practitioner regulatory capacity and enforcement are weak to begin with, emergencies can increase the risk to patient safety when regulation is relaxed *(224, 262)*. Mechanisms to mobilize a surge workforce for regional and international responses to emergencies, such as disease outbreaks, disasters and political conflicts, in a coordinated manner (for example, through agreements between regulators and/or between governments) could minimize such risk. During emergencies, regulators should be allowed to establish streamlined authorization of practice processes for internationally qualified practitioners. Regulators should also have the power to fast-track the verification of qualifications and the probity of applicants and to grant time-limited and/or limited-scope authorization to practice, subject to any conditions the regulator considers necessary to mitigate the risks and ensure safe practice.

Institutional structure and governance mechanisms should promote the consistency, efficiency, transparency and accountability of regulators

4. Legislation and institutional structure

In case of a statutory regulation environment, consider an "umbrella" law or legislative framework for all health practitioners and a multipractitioner regulatory agency to improve consistency and regulatory collaboration, while preserving responsiveness to the specific risk profile of each health occupation.

Legislation on the regulation of health practitioners is essential in providing a legal mandate and foundation for regulators. It can also contribute to transparency, public accountability and consistency in the purpose, operations and performance of the regulators. The design of legislation depends on contextual factors such as: constitutional provisions; political and governance systems; the structure of health, education and legal systems; and the generic laws that apply to occupations in general.

The law could apply to all, multiple or specific occupations and for selective or all regulatory functions. On the one hand, regulating health practitioners from multiple occupations under a single law can increase efficiency and consistency and enable better management of demarcation disputes between different practitioner groups, as opposed to the conflicting or overlapping mandates and provisions, and can reduce the resource burden arising from multiple laws *(26, 198, 175, 173)*. It may be easier for governments to update a single law to make it more relevant to contemporary needs and priorities. Such a law might also be simpler and more efficient to enforce, which would lessen the burden on administrators of having to comply with multiple legislations. It is also simpler for other health, education and labour actors and the public to refer to and engage with a single law instead of navigating the complexities presented by a raft of legislative instruments, with one for each occupation or occupational group.

On the other hand, specific legislation for regulating each health occupation might increase the potential for conflicting provisions or legislative gaps across occupations. It might also increase the administrative and resource burden on regulators (with limited capacity or functions), the practitioners and the public.

A possible concern about an umbrella law is that it might carry the risk of dominance by one or several health occupations. Yet, occupation-specific legislation may be more tailored to a particular occupation and present the opportunity to compare the results of different laws. This would make it possible to assess which approaches are more effective and to identify innovations. However, depending on governance and accountability structures, selective occupations may retain dominance even within occupation-specific laws, with the risk that they are exclusively prioritized for legislation updates.

Governments should weigh the costs and benefits to the public before deciding on the appropriate legislative framework governing the regulation of health workers. Legislation can also be designed to combine the advantages of both single and occupation-specific laws while minimizing the associated disadvantages. An umbrella law could specify the broader purpose and principles for the regulation of all health occupations and foster collaboration between regulators in areas of common interest, while still providing independence and adequate provisions to bring in profession-specific expertise *(29, 31, 263, 264)*.

Where applicable, countries lacking a legal basis for health practitioner regulation should consider adopting a single umbrella law. Conversely, countries that already have separate laws (either for health occupations or for subnational levels) should consider whether these provide an adequate and consistent mandate for regulation and whether they advance patient safety and their health system goals. In terms of opportunities to improve consistency and alignment, developing an overarching legal framework for all disciplines or regulatory functions can be an opportunity to improve consistency and alignment. Legislation should define the purpose, principles and criteria for regulating health occupations, including the possibility of updating the list of regulated occupations. It should specify the accountability structure and include provisions to enable the public scrutiny of regulatory actions. The mechanism and the functions of the regulatory entity (or entities) may differ between occupations and jurisdictions or countries. However, the law should grant adequate powers to the regulatory authority to permit new and innovative approaches in keeping with the changing needs of the health system and enable flexibilities during emergencies (with appropriate safeguards).

In federated contexts, and when consistent with the respective constitution and legal framework, a single national law or legislative framework on health practitioner regulation may increase efficiency and consistency *(26)*. It can also encourage the domestic mobility of practitioners across state or provincial borders *(159)*. However, when subnational jurisdictions have different regulations, competition among different models can result in improvements in the regulatory frameworks.

In settings with substantial subnational variations in geography, economy, social development and strength of governance – or where a single national law is not compatible with the federal structure of the country – uniform standards and processes under a national law may not always be aligned with the priorities and realities of the subnational health systems. As a

result, there may be implementation challenges *(44, 168, 265)*. In such cases, coordination between different levels of government and adequate stakeholder consultation are crucial to ensure that the law is designed in such a way that the subnational level has sufficient powers to address local needs while retaining the advantages of national legislation or to harmonize subnational laws. Decentralization of certain regulatory functions could also bring regulation closer to the communities, particularly to those who have limited access to regulatory systems.

Regardless of the type or differences in legislation, frameworks or regulatory bodies, there can be operational flexibility, such as provisions for a common secretariat to share infrastructure and administrative resources *(174)*.

The same principles apply to the agency administering the regulatory functions (Box 6).

Box 6.

The ability of the regulatory agency to function effectively is more important than the number of occupations it regulates or its institutional structure

Depending on the context, a single agency may administer regulatory functions for all health practitioners, for practitioners of selected occupations or a single occupation, and it can be responsible for all or selected regulatory functions. The preferred structure of the regulatory body depends on factors such as the efficiency of the system, the size of the regulated workforce, the function and organization of the regulator, the resources available to carry out responsibilities and the relationship between regulators.

While evidence is inconclusive, key rationales for having a multipractitioner regulatory agency for all or selected health occupations, including applicable professionals, associates and assistants, are: shared administrative resources and the provision of economies of scale; increased capacity; improved inter-practitioner standard setting and collaboration; and streamlined coordination with regulators and quality assurance systems *(164, 174, 175)*. This makes it easier to access data from different practitioner registries and can facilitate the harmonization of regulatory processes, especially complaints and discipline, bringing clarity and ease to the public and employers, particularly on navigating the system to access practitioner information and lodge complaints.

When a new occupational group is regulated, it is more economical to use an existing regulatory agency rather than set up a new one. The approach of a single regulatory agency could, therefore, be relevant in contexts where capacity constraints hinder the establishment of regulatory agencies or limit the implementation of regulatory functions *(266, 267)*; though a multipractitioner regulatory agency can help to address the challenges associated with a silo-based approach, it should preserve responsiveness to each specific occupation and its risk profile.

There may be stiff opposition from those who want to preserve the existing situation rather than reforming separate regulatory institutions into a single agency model. When the number of health practitioners is large enough for efficiencies of scale and the targeting of expertise, and there is established administrative, governance and regulatory capacity for practitioners of each occupation, the operational cost-sharing advantages of an integrated regulatory agency may be limited. Furthermore, when adopting a single regulatory agency model, there is a risk that excessive functional separation by occupational group might simply be replicated within the structure of the umbrella regulatory agency. This will not solve the fragmentation problem, but simply shift its institutional locus.

However, separate regulatory agencies could result in inconsistencies and hinder the delivery of different models of training and health services, such as interprofessional education, blended learning, team-based practice and telehealth. In such cases, common regulatory principles and approaches as well as formal mechanisms for coordination and policy alignment can strengthen synergy between the different regulators, even when they remain distinct and independent institutions.

Investment in regulator capacity should also be a priority. The functionality of any regulatory agency depends in part on the capability and resourcing of its staff. It is crucial that the regulatory agencies are adequately staffed and that their workforce has clarity on its roles along with the mandate and expertise to fulfil its responsibility. Care should be taken to ensure that any additional responsibility being placed on a regulatory entity is accompanied by the necessary capacity, support and resourcing.

The financing mechanism for regulation is an important element in ensuring that regulators can perform their functions. Financing sources typically include accreditation fees, registration fees and government or employer contributions. Since the fees charged should be commensurate with the level of regulatory effort and resources required for the regulatory function, the sharing of administrative resources between regulators of different occupations would be cost-effective. This is especially the case where the registrants do not generate sufficient revenues to maintain the regulatory functions because they are too limited in number or unable to pay the fees (since the required contribution is often high relative to their pay scale).

5. Governance and oversight

Adopt clear governance arrangements, with adequate state oversight for regulators, to ensure that they serve the public interest.

The responsibility for regulatory functions can lie with a single agency or several agencies, including a mix of government and nongovernmental entities responsible for specific functions. Regardless of these arrangements, role clarity, clear governance mechanisms and adequate state oversight of regulatory entities are important.

The governance mechanism of regulation should ensure that the regulators work to advance the public interest. Unmanaged conflicts of interest in the composition of regulatory bodies (such as when many regulators represent practitioners being regulated) can lead to regulatory capture or abuse of power. For instance, over-restrictive entry requirements may be established to create unnecessary barriers to market entry, thereby inflating the wages and income of the incumbent practitioners at the expense of the public and government. Oversight is also required to ensure that regulatory processes are based on evidence to advance the public interest and not simply to generate revenue for the regulatory body.

A regulatory body composed of a mix of the public, practitioners and government could balance power across different stakeholders, as opposed to one group with a selective interest holding exclusive power. Where regulators are independent of or have some degree of autonomy from the government, state oversight is necessary to ensure that they work to advance public welfare and broader health system priorities.

The selection and appointment of members of the governing boards of the regulatory body should be transparent and consistent, with clear and objective criteria. So as to minimize the risk of conflict of interests, all health practitioners serving in the regulatory body should be appointed on the basis of their expertise and not because they represent an association or union of the workforce being regulated *(41–43, 85)*. Similarly, individuals who are responsible for accreditation or monitoring the compliance of educational institutions with regulatory standards should declare any competing interest, such as also being providers of education or members of governing boards of institutions requiring accreditation.

The public and practitioners can trust regulatory activities and decisions if the regulatory body and its personnel are (and are perceived to be) impartial, honest and transparent. Similarly, transparency in regulators' activities, including financial aspects, will help to maintain confidence in their operations and enable performance assessment.

Regulatory functions should promote patient safety, quality of care, and the accessibility and competence of practitioners

6. Scope of practice

Determine practitioners' scope of practice based on their education, skills and demonstrated competence, supported with appropriate governance and clinical oversight.

Regulation should enable health practitioners to work within their full scope of practice together with appropriate safeguards. Flexibility for expanding the scope of practice of all health practitioners, supported by adequate training, expertise, governance and accountability structures for patient safety, can improve access to quality health services *(52, 53, 268)*. With the adequate collaboration of actors responsible for patient safety (regulators, employers, practitioners, businesses and patients/users), the detailed scope of practice for health practitioners may be determined according to the clinical environment in which the practitioner works, but instances of patient harm should be subject to appropriate regulatory actions *(268, 269)*.

When a law defines too tightly the details of the scope of practice of an occupation or unnecessarily restricts tasks to certain occupations, it serves as an obstacle to meeting population health needs. This challenge occurs when regulations do not allow health practitioners to perform certain tasks despite fulfilling training requirements and demonstrating competence, and when they do not allow individual practitioners to expand their scope of practice with the necessary competence. It also occurs when the exclusive scope of practice (reserved activities) for a given occupation is unnecessarily large and prevents other practitioners from providing these services. Over-restrictive regulation on the scope of practice can also represent an obstacle when responding to changes in health service delivery (such as collaborative team-based care) and can hinder innovative advanced practice and assistant roles to meet changing population health needs.

The regulator's position on scope of practice of any health occupation should enable sufficient flexibility in the workforce to meet the needs of service delivery without compromising patient safety *(114)*. There are multiple levels at which the scope of practice could be determined (such as by the regulator, employer or individual practitioner). Its delineation, including reserved or restricted clinical procedures and prescription authority by licensure or registration should, therefore, be based on the complexity of tasks and the potential risks to patient safety, rather than the occupation to which the health practitioner belongs. Complex tasks with a high-risk profile should be reserved for highly skilled practitioners while greater flexibility should be considered for simpler lower risk tasks, allowing wider groups of practitioners to perform them. In conjunction with the employers, regulators need to provide guidance to practitioners and employers on how to determine the limits of scope of practice and the qualifications needed to expand it. Regulators also need to make information publicly available on practitioners with restricted registration or licence, undertaking internships or with limitations on registration or licence due to disciplinary actions.

The historical division of labour and the economic effects of scope-of-practice regulation can influence health practitioners to protect their vested interests, which are linked to income opportunities and professional prestige. For example, the exclusive scope of practice (reserved activities) for a given occupation can be kept unnecessarily large preventing other practitioners from providing these services and, thus, preserving revenue potential rather than protecting patients. However, the regulator's position on scope of practice of any health occupation should always be in the best interests of the patient, aligned with advancing health system priorities and service delivery needs, and ideally informed by context specific evidence. Transparent criteria and/or processes for making decisions can help to ensure that any changes to scope of practice are shaped by evidence as opposed to pressure from a stakeholder group.

7. Entry to practice

Requirements and processes for entry to practice should be based on setting and enforcing minimum standards of competence and probity, in order to provide safe and quality services to meet population health needs.

Regulatory standards and requirements for entry to practice are intended to ensure that practitioners have the minimum competence to provide safe and appropriate services. However, these conditions may affect the availability of health practitioners which, in turn, influences the public's access to and cost of health services. Regulatory requirements and pathways for entry to practice should also enable practitioners to meet broader health system goals. Higher standards for entry to practice are warranted only when the demonstrated benefits to the public's health outweigh the costs.

The requirements for entry to practice in a jurisdiction may vary in response to a practitioner's risk profile and to the needs for service delivery. In all cases, however, setting and applying minimum qualification standards, probity and other requirements should be transparent, objective, impartial, fair and not more burdensome than necessary *(97, 98, 240, 270–273)*. Relevant entry-to-practice standards should apply to both the public and the private sector and include foreign-trained practitioners.

Depending on the context, the requirements for entry to practice may include, but are not limited to, one or more of the following *(115, 121, 122, 133, 274)*:

- common entry examinations or standardized tests for entry to educational programmes
- graduation or certification from accredited educational institutions or programmes
- certification of training completion
- completion of registered or certified apprenticeship programmes
- licensing examination (or exit examination from educational institutions)
- recognition of qualification and practice experience, particularly when obtained in another country/jurisdiction.

In addition to technical competence and recency of practice, assessment of personal characteristics and attributes could also be considered, such as:

- language fluency
- criminal history
- disciplinary history including in other jurisdictions
- fitness to practice (such as the physical and mental health condition of the practitioner, which may compromise their capacity to work and place the public at risk of harm)
- good character (recognizing that attitudes and values related to moral behaviour can vary according to cultural and social norms).

An optimal combination of standards for entry to practice should enable practitioner availability at affordable cost, while maintaining patient safety. Low standards and loose processes for entry to practice could lead to health practitioners of variable quality, while excessively high standards and complex processes carry the risk of restricting the availability of practitioners and increasing the cost of services. Both situations have negative implications for the public, in terms of the quality of and access to services.

When standards for entry to practice are left to the discretion of health practitioners, the conflict of interest may result in standards being placed at higher levels to create a barrier to market entry *(15, 275)*. When regulators set minimum national standards in countries with large variations across subnational jurisdictions, they need to consider trade-offs between the advantages, unintended consequences and feasibility of enforcement *(44)*.

Governments should regularly review and update the legislation and regulatory arrangements to keep pace with advances in science, changing population characteristics, public expectations and service delivery models. Accordingly, entry-to-practice requirements and processes need to be updated or new occupations included or removed from statutory regulation, as applicable. When new provisions or new health practitioners are included in the regulatory framework, "grandparenting" clauses may be needed to ensure appropriate provisions for those already in practice before substantive changes in regulation are enacted.

Regulators can consider encouraging new models of pre-service education with an appropriate balance between theory and practice as well as new pathways for entry from across disciplines, particularly in areas facing workforce shortages. This could include appropriate education and the training and regulation of informal practitioners in underserved communities to ensure that the services provided do not harm patients or users. Depending on contextual needs, regulators may also consider permits for a limited scope of work, supervised practice, nonclinical work and temporary permits.

8. Accreditation and licensing

Accreditation and licensing should be based on clear standards to ensure the quality of educational institutions and programmes of study and the competence of graduates and health practitioners.

Both accreditation and licensing ultimately aim to ensure the competence of practitioners. The purpose of accreditation is to ensure the minimum quality of the education programmes or institutions that impart a minimal level of competence to the graduates. Licensing assures that the individual practitioner has the minimum competence required to practice in a jurisdiction.

Accreditation mechanisms should ensure that the quality of education provided is aligned with entry- to-practice standards and the service delivery needs in the jurisdiction and that it is coherent with the respective government health and education policies. Elements for accreditation of training programmes may include *(14, 118, 276)*:

- standards relating to quality in the provision of learning activities
- standards relating to the assessment of the achievement of learning outcomes
- specification of education outcomes defined in relation to entry-to-practice standards, population health and health service needs
- alignment with government policies on health workforce education.

Flexibility in accreditation systems can encourage innovative models of education and facilitate multiple pathways for entry to practice. According to service delivery needs and contextual requirements, timely updates to the regulatory provisions on the contents of undergraduate and postgraduate curricula and pre-service education of different disciplines, interprofessional education and blended learning programmes and apprenticeship programmes should also be taken into consideration.

If the accredited health practitioner educational programmes in a jurisdiction can assure the standard and competence of graduates, the qualification of health practitioners can, in some cases, be considered sufficient by regulators and employers for assessing the technical competence of an individual practitioner. Alternatively, if there is variation in the educational programmes or the programmes do not adequately respond to service delivery requirements or the risks to patient safety are high, additional controls may be necessary to ensure the minimum standards of individuals entering practice *(133)*.

Licensing examinations represent an additional layer of quality assurance to ensure the competence of individual health practitioners, particularly where the tasks carry substantial risk to patient safety. Such examinations are used to screen practitioners for minimum theoretical and clinical knowledge and/or the skills required to practice. However, their structure and contents vary between countries since they are tailored to specific contexts. Adopting an examination that has been developed for another country without contextualization carries validity risks. When considering a licensing examination, it is crucial to identify the most suitable approach, to align it with entry-to-practice standards and the local context, including language and qualification requirements *(121)*.

When the responsibility for the regulation of educational institutions and programmes and the practice of individual health practitioners is split between different entities, coordination between them is essential in ensuring that the content and quality of education and entry-to-practice standards are aligned with health service delivery needs. Therefore, collaboration between regulators, educational accreditation systems and health authorities is crucial.

Market forces play a strong role in the proliferation of private educational institutions of variable quality, particularly in LMICs. Where regulators have inadequate capacity, the enforcement of standards is poor, which can have negative consequences on the quality of health services *(74, 212, 215, 277)*. Conversely, excessive rigidities in increasing the number of accredited training institutions or student intake, which is a more prevalent scenario in HICs, could result in the insufficient production of new health workers *(92)*. The extent to which health practitioner regulators can contribute to addressing these types of failures in the health labour market depends on respective government policies, government participation in health practitioner regulation, and the authority granted to regulatory bodies.

9. Qualification recognition

Recognition of qualifications across jurisdictions should be based on assessing similarities and differences in education and whether they provide the necessary competence for entry to practice.

Qualification recognition entails the acquired competencies being completely or partially portable across national and subnational jurisdictions. It could also be applied to the portability of acquired knowledge and skills when health practitioners switch to another health profession (for example, from dentistry to medicine). The portability of qualifications should be determined by an assessment to identify the similarities and differences in the educational programmes and/or competence requirements between countries or regulators. It should also be linked to appropriate mechanisms to address the differences.

When economies, geographical setting, education, health and legal systems, language, public health priorities and the division of work among health practitioners in two countries or jurisdictions are alike, the regulatory standards may be similar enough to be considered equivalent. At the same time, practitioners in two countries may have the same professional title or educational degree, yet the differences in the educational or training programmes, practice environments, their scope of practice, public health priorities and language of communication could be substantial. Therefore, regulators need to determine if the qualification acquired in another jurisdiction meets their standards. If not, they should provide a framework with specific requirements to bridge the gaps (such as additional education and training or work experience).

The standards and processes for evaluating qualification should be transparent, fair, objective and nondiscriminatory *(270, 271)*. Evaluation methods may include or consider: the verification of credentials; an appraisal and verification of work experience or additional training; and the formal assessment of competence *(26)*. It should be noted that qualification recognition may be only one of the requirements for entry to practice in a jurisdiction (as discussed in policy consideration 7).

When adjusting the regulatory requirements to meet regional or international standards, regulators should ensure that local priorities are not overlooked and that controls are in place to address any possible negative consequences for the health system. Any provisions related to international recruitment or mobility of health personnel should always be aligned with the *WHO global code of practice on the international recruitment of health personnel (278)* and other relevant international instruments. It is also important for regulators to be involved in the development of government-to-government agreements on the mutual recognition of qualifications or on the migration and mobility of health practitioners. They should agree on the assessment of regulatory standards and processes between countries and determine the best approach to integrating practitioners who obtained their qualifications in another jurisdiction.

10. Maintenance of competence

Regulatory schemes should have mechanisms for assessing and assuring the continuing competence of practitioners.

The minimum standards of health practitioners that were assured for entry to practice need to be maintained for consistency of practice and patient safety. Depending on the risk profile and contextual factors, relevant tools that regulators can use to assure the continuing competence of regulated practitioners in public and private sectors may include *(124, 133, 279, 280)*:

- demonstration of recent practice experience
- performance assessments, audits and inspections
- investigation of complaints or noncompliance with regulatory standards
- CPD activities that focus on addressing practitioners' individual professional learning needs relevant to the environment in which they work and linked to observations in improvement in practice
- peer review or appraisal of practitioner performance and evidence of patient outcomes
- establishment of a regular revalidation programme or regular demonstration of competence
- renewal of registration or licence to practise.

More investment in proactive regulatory levers may reduce the need for reactive regulation. Contextual specificities, government policies and regulatory capacity determine which would be the most appropriate measures. Some examples are:

- routine periodic assessment of performance or competence
- inspection after reports of noncompliance
- peer or user appraisal of performance (or combinations thereof)

- appropriate and relevant CPD programmes linked to the measurement of practitioner performance, in coordination and collaboration with employers and practitioners.

Practitioners' registrations or licences could be renewed by some regulators once the requirements of the revalidation programme have been fulfilled, while other registrations or licences could be valid for life unless removed by the regulator for violations as specified by law *(26, 245, 266)*. The selection and frequency of use of the tool to assure competence maintenance should be feasible and ideally based on context specific evidence that shows improvement in patient outcomes. It should neither simply serve as a source of income for regulators nor represent an administrative burden for practitioners.

The standards and requirements set by regulators for practitioners to maintain registration should align with the clinical environments in which those practitioners work. The infrastructure of health facility, the role of other practitioners in health care teams and the availability of medications, supplies, technology and referral services all have an influence on practitioners' performance. These factors need to be considered during the assessment. When inspections and performance assessments are undertaken and/or developed jointly with other regulators of the health sector, they can help to coordinate regulatory standards, processes and decisions and to identify approaches to improve service delivery *(149)*.

Regulators should have adequate consultation with practitioners before determining the requirements to maintain their registration in such a way that it avoids penalizing disadvantaged health practitioners. Rigid requirements, such as hours of full-time practice, could negatively affect part-time practitioners who have care-giving responsibilities or practitioners returning from maternity leave or recovering from physical and mental illness. Regulator-mandated CPD requirements could also place practitioners in some geographical areas or certain practice specialties at a disadvantage in terms of access, cost and/or relevance, which should be avoided.

11. Dealing with noncompliance

Regulatory schemes should have clear mechanisms for dealing with departures from professional standards, with a focus on public protection and remediation, and ways in which the public can raise concerns with the regulator.

One of the core functions of regulators for protecting the public is managing practitioners' and educational institutions' noncompliance with regulatory standards. Noncompliance with standards may relate to practitioner competence (performance), conduct (discipline) or personal fitness (health). Depending on the authority granted to the regulator, there may be differences as to the role and power of health practitioner regulators, employers and other institutions, such as judicial authorities, in terms of dealing with noncompliance with standards and expected conduct *(246)*. Therefore, the regulator needs to establish protocols for working with a range of bodies, including employers, when dealing with complaints and managing discipline.

The process for dealing with departure from standards needs to be consistent, transparent and fair. Information on filing complaints and the investigation process should be accessible to the public. The process could include lodging a complaint, assessment, investigation, health/performance assessment, immediate action and panel hearings. These processes should be efficient and streamlined to ensure timely and cost-effective investigations and actions on the complaint. The right to a fair hearing, freedom from bias and the right to appeal to a fresh decision-maker are important elements of procedural fairness in handling complaints and discipline *(176, 246, 281–283)*. Functional separation between investigation and prosecution, or the establishment of an independent tribunal for health practitioners, can help to address conflicts of interest and personal biases *(34, 36, 281, 284)*. Where possible, a single adjudication for all practitioners in a reported case can reduce the administrative burden and ensure consistency in outcomes.

If warranted by the investigation, the regulator's disciplinary action against the health practitioner may take place in the form of an imposition of terms, conditions and limits on scope of practice, warnings, suspensions, revocation of a practice licence or referral to other entities. Where applicable, the criteria for practitioners who have been suspended from the registry to be remediated and the process for them to return to practice need to be transparent *(82)*.

Similarly, subject to country laws, dealing with noncompliant health practitioner training institutions may range from warnings and a grace period for improving on specific items to de-accreditation, graduates not being eligible for registration or employment and closure of institutions.

The regulator should share the information on disciplinary actions against practitioners and/or the educational institution with the public. The inclusion of disciplinary history in public registries can help patients, clients and employers to make informed choices about practitioners. Regulators can use the data to identify and reduce the risk of harm to the public through preventative action or early identification and intervention *(83, 152–154, 285–287)*.

Health practitioner regulation can be used to support health system priorities

12. Practitioner data

Regulators should harness health practitioner registration systems to generate and share data on graduates and active practitioners to support workforce policy, planning and monitoring.

A core function of regulators is to maintain a publicly available registry on regulated health practitioners that is accurate, complete and includes information on practitioners who have been removed from the registry. This enables access to information on practitioners by both the public seeking services and employers recruiting the practitioners.

Depending on the occupation and jurisdiction, the information in the public registry can vary. The health practitioner registry accessible to the public is in compliance with legislation and requirements on confidentiality and the handling of personal data and generally includes relevant information on the practitioners such as name, gender, age, registration number, qualification details (such as basic and additional qualifications, conferring institution, year conferred), scope of registration or licensure, disciplinary history and associated sanctions and actions *(26, 115, 286–288)*. Since maintaining an up-to-date public registry has resource implications, the costs and benefits should be assessed for each data point included in the register.

Information shared in the public registry is only a subset of the information that is collected by the regulators. Additional information captured by regulators could include practitioner characteristics such as language skills, country of birth, nationality, details on practice location, criminal history records, fitness to practice, and complaints and disciplinary actions. Information on employers may also be captured *(26, 289–292)*. Some of the information held by regulators is confidential and the grounds on which this information may be shared and with whom need to be specified by law.

Similarly, the regulator for health practitioner education could hold information on the capacity of the institutions as well as annual data on enrolments and graduates (if applicable) in different programmes, including gender, age, country of birth and the nationality of students.

Where assessments of practitioner performance standards are regular and linked to periodic registration or licensure renewals, it can help to keep the practitioner registry updated. In such cases, the available data (for example, on education, entry to practice, maintenance of standards, complaints and discipline) should be analysed to detect clinical governance failures that harm patients, identify innovations and generate evidence and data for improving regulatory systems, practice environments, service delivery and patient safety *(84, 152, 154, 285)*.

Electronic information systems on health practitioner registries, licences, complaints and disciplines are more accurate, efficient and easier to manage. They enable the sharing of relevant data but also require resources to set up and maintain. Increased efficiency of the regulator with electronic systems can also result in improved adherence to the regulatory requirements, which can in turn generate revenue for the regulatory agency *(48)*. When the practitioner database maintained by the regulator is accurate and contains sufficient information, it can be integrated into the national human resource for health information system (within the applicable boundaries of necessary confidentiality and interoperability of the information systems). It would thus serve the additional function of providing relevant data to inform health workforce planning and management *(48, 287, 293–295)*. Regulators in LMICs who are about to undertake digitalization of health practitioner databases, including registries, could design information systems that can be integrated (between regulators and government entities, as applicable), as opposed to countries who have already invested heavily in systems that differ across occupations or regulators.

Information on health practitioners held by regulators can potentially be useful when collaborating with other relevant stakeholders to generate, share and maintain interoperable data on graduates, health workers who are considered fit to practice, and students. Depending on how the data are maintained and the information held, a registry could be an information source when conducting an analysis of the health labour market. Coordination between entities and the stakeholders responsible for collecting or maintaining data on health practitioners at different stages of education and practice – such as entry into training programmes, graduation, entry into practice and location, mobility and exit from practice – can help to create a single platform on which to access data on health practitioners.

13. Partnership across jurisdictions

Establish an effective link with regulators in other jurisdictions to facilitate coordination on practitioners' mobility, migration, international service delivery and accountability, and the public's access to services.

The international mobility and migration of health practitioners and the international delivery of health services through health-related travel and telehealth are increasing. International practitioners often provide surge support in major emergencies. International volunteerism among health practitioners is also common in some contexts. However, the authority or actual capacity of a regulator might often be limited – de jure or de facto – to practitioners within its national or subnational geographical borders.

Regulatory convergence between jurisdictions with sufficient similarities could: reduce the administrative burden of regulators while they are assessing practitioners with foreign qualifications; encourage practitioner mobility; and increase public protection. However, this may not always be practical considering the large contextual differences between countries.

International (and subnational) coordination and collaboration, while not a primary function of regulators, can be instrumental in the sharing information on relevant requirements for entry to practice, competence, performance assessments and the investigation of complaints and disciplinary processes in another jurisdiction *(125, 255, 296)*.

When communication between regulators is weak, the movement of health practitioners or cross-border delivery of services can enable practitioners to avoid disciplinary action by moving to another jurisdiction. The lack of communication between regulators is often because of licensing laws or data protection laws, which prevent the regulator from sharing information with other regulators about practitioners who have restrictions on their licences. This may, however, create a significant risk of harm to the public. The risk of harm to the host population from short-term foreign practitioners is greater when the shortage of health practitioners is severe, when the capacity to enforce regulations is weak and when access to health services (for follow-up consultations or management of any adverse effects of the intervention provided) is limited or nonexistent *(222–224)*.

Regulators with stronger capacity should be aware and considerate of the limitations and challenges faced by their counterparts in low-resource settings and develop feasible arrangements to ensure competence, probity and liability of their registrants for practice abroad. Regional and international forums and networks of regulators can provide opportunities to share information, discuss challenges and best practices, hold consultations on areas of mutual interest and identify opportunities to strengthen institutional capacity.

14. Health worker distribution

Regulatory schemes can be used to support the equitable distribution of health practitioners in rural, hard-to-reach and underserved areas.

The inequitable distribution of health practitioners in rural, hard-to-reach and underserved areas, where half the world's population resides, is a challenge faced by almost all countries. It requires interventions that are interconnected, bundled and tailored to the local setting *(95)*. For health practitioner regulation to be leveraged to support the production, development and equitable distribution of practitioners, it should be aligned with broader health system goals. However, in the process, care should be taken to avoid any diversion from the primary purpose of the regulation (in other words, ensuring the public receives safe health services).

In alignment with the WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas *(95)*, regulatory interventions to support the more equitable distribution of health practitioners in underserved areas may include, depending on contextual needs:

- expansion of scope of practice for existing health practitioners
- determining the pathway for entry or any regulatory intervention when introducing new types of health practitioners to meet the needs of specific areas

- the provision of scholarships or other educational subsidies linked to accreditation (with agreements for return of service from health practitioners linked to certification, registration or licensing)
- streamlining regulatory requirements for the establishment of health practitioner educational institutions in underserved areas, and students from under-represented communities or underserved areas for entry to health practitioner educational programmes
- ensuring that health practitioner educational programmes include postings in rural and underserved areas
- linking diploma or licensure release with compulsory service requirements that respect the rights of health workers and are accompanied by support structures and incentives
- introducing limited registration to work in underserved areas (for example, to support local capacity-building in a specific area) as determined by the relevant authorities and in alignment with government policies
- introducing pathways to enter new or specialized practices tied to work experience in underserved areas
- enabling regulatory provisions for introducing context relevant technology-assisted education and practice in underserved areas.

The extent to which the health practitioner regulator can influence the production and distribution of practitioners is dependent on government policies, health labour market conditions and the authority granted to the regulator.

15. Dual practice (in public and private sectors)

Regulatory measures could be used to facilitate positive outcomes from dual practice and to mitigate its adverse or unintended effects.

Dual practice is a widespread phenomenon in countries at all levels of socioeconomic development. It can affect the equity and quality of health services, especially if unmanaged. Legislation on dual practice varies across jurisdictions depending, for example, on the private/public nature of the health system and employment laws *(297)*. Its application has implications for: patient safety when practitioners deprioritize the care of patients in one setting in favour of patients in another setting *(217)*; health service distribution when practitioners prefer to remain only in locations that allow them to engage in dual practice *(104)*; and equity and service availability, since dual practice can reduce waiting times for those patients who can afford services in the private sector *(298)*.

In alignment with government policies and enforcement capacity, health practitioner regulators could utilize certain measures to mitigate the negative effects and facilitate positive outcomes from dual practice, especially when there is a shortage of health practitioners. These could include:

- setting requirements for entry into practice in the private and public sectors, respectively *(103, 299, 300)*
- specifying services that can be provided in private practice *(103, 299)*;
- setting, contributing to or clarifying rules regarding responsibilities towards patients and clients
- including information on workplaces in the registry of practitioners
- setting or contributing to rules on how employers can track the hours spent at public and private work sites
- evaluation of the data on practitioner performance or complaints, if available.

Regulation of dual practice varies across the different health practitioner groups and jurisdictions. It also depends on the governance of the health workforce, employment laws, market policies and the authority placed on the regulator, employers and other government entities. Effectively managing dual practice is primarily the responsibility of employers and includes: guaranteeing a minimum number of working hours for public sector service; limiting the number of working hours dedicated to private sector practice; and restricting the use of public sector resources for private profit. Additional instruments that can be adopted in collaboration with regulators and employers may include the application and enforcement of codes of conduct and requirements to seek permission from principal employers before engaging in dual practice.

Chapter 6

Evidence gaps and research agenda

The integrative review to inform this guidance included published and grey literature. The examination of a wide range of evidence made it possible to understand the diverse contexts and perspectives. However, the published literature was largely descriptive, with only two comparative studies that evaluated how differences in the legislative, governance and administrative arrangements or the different functions and operations affect patient safety. The lack of a common taxonomy on health practitioner regulation also made it difficult to undertake a comparative analysis of findings from a variety of sources.

Furthermore, the published literature – half of which was from five Anglophone HICs – focused on medical and nursing personnel. These five countries represent approximately 6% of the world's population and 2.5% of WHO's Member States and host 18% of the global stock of medical doctors and nursing and midwifery personnel (43% of the stock in Organisation of Economic Co-operation and Development Member countries). The dominance of literature from a few selected countries, which partly reflects the broader research landscape and funding availability, makes the evidence only representative of selected professions in HICs. Although additional resources and the expertise of the TEG have also informed the contents of this guidance, it may not have fully captured the relevant good practices, innovations, issues of concern and challenges that exist in diverse settings or the regulation of health practitioners with lower risk profiles.

Given these gaps in the evidence, future research is necessary to generate a more robust evidence base concerning health practitioner regulation in different contexts. It should prioritize the following elements.

(1) **Standardizing the taxonomy and terminology on health sector regulation**. More consistent definitions on regulation should be adopted to enhance global understanding of health practitioner regulation and enable comparisons of different mechanisms. Such comparative analysis will generate evidence on effectiveness and the impact of different models and mechanisms on patient safety and other dimensions of public interest, contributing in turn to the design of regulatory systems.

(2) **Understanding health practitioner regulation and the practice gaps in diverse contexts.** Identifying the regulatory structures, powers and processes as well as the extent and causes of the regulatory practice gaps in different settings and for different health occupations will require new kinds of evidence from LMICs and non-Anglophone HICs, including the categories of practitioners other than medical and nursing personnel. This will also provide context-specific evidence on viable alternatives to statutory regulation, particularly for health practitioners with a lower risk profile. The development of surveys and administrative data on occupational regulation can help to provide a better picture of on-the-ground realities.

(3) **Identifying the outputs, outcomes and impacts of health practitioner regulation.** Given the vital role of health practitioner regulation in enabling health service delivery, evidence should be generated on how best to use regulation to advance broader health system goals (including its effect on or alignment with education and service delivery reforms, health

[12] Based on 2020 data on national stock of doctors, nursing and midwifery personnel in National Health Workforce Accounts Data Platform.

system performance and population health outcomes). Different institutional and governance arrangements for health practitioner regulation could be evaluated against a standardized framework to inform understanding of what would be more effective in specific contexts. An awareness of how other elements contribute to patient harm in health care settings, the extent to which health practitioner regulation contributes to health outcomes, and the role of other policy and system levers in successful regulation could minimize the unintended consequences of regulation.

(4) **Adopting a gender and intersectional lens in regulation research.** In addition to the general limitation in evidence on the effectiveness of regulation, the literature is largely gender-blind, ignoring any differential gender impacts of regulation. The review did not find any other dynamics between demographic and socioeconomic factors (such as age, disability, nationality, ethnicity, geographical setting, socioeconomic status and migration or refugee status) and how these interact with regulation. Disaggregating the data and adopting a gender and intersectionality lens in the analysis could lead to a richer understanding of the impact of regulation and could enable gender- and intersectionality-informed guidance and the implementation of gender-responsive regulations.

(5) **Identifying the most cost-effective regulatory measures to secure the public's welfare.** Evidence on the relative benefits and costs of existing regulatory mechanisms, processes, standards and liabilities in achieving objectives can inform the strengthening of the design, implementation and reform of regulation in different contexts. Robust evaluation of the impact and resource requirements of regulatory approaches, mechanisms and processes on patient safety and health worker quality can increase understanding of what works and what does not work in different settings.

(6) **Evaluating regulatory flexibilities and adaptions during the COVID-19 pandemic.** The pandemic highlighted the crucial role played by regulators in enabling workforce availability during emergencies. It also emphasized the importance of responding to shocks, agile regulatory processes, alignment with health system priorities and of effective linkages with other regulators and stakeholders. Evaluating regulatory changes and innovations during the COVID-19 pandemic is an opportunity to generate evidence that could inform the changes that should be maintained in the long-term and the flexibilities that require more control and should be applied in future emergencies.

The shortage of experimental studies that generate strong evidence on effective regulatory systems for health practitioners points to the need to prioritize operational research in different contexts. Such studies, especially in LMICs, require targeted funding and capacity development of research institutions to strengthen the evidence base for health practitioner regulation and to address the regulatory practice gap.

The literature review informing this guidance provides a valuable resource on health practitioner regulation. The rich descriptions of the diversity of regulatory systems, reforms, challenges and practice gaps identify significant areas requiring research, which will help to inform the development of more granular and context-specific recommendations on health practitioner regulation in the future.

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Annex

Summary of research methods

Summary of research methods used in the scoping review

An initial scoping review was conducted to inform the first discussion of the WHO Technical Expert Group on health practitioner regulation, to help determine the focus of the forthcoming guidance and to steer the development of the systematic review research questions

The primary objectives of the preliminary step (the scoping review) were to: identify a suitable framework for the subsequent systematic review; categorize the different systems of health practitioner regulation and their scope; identify examples of the mechanisms and impact of regulation; and illustrate regulatory reforms and challenges.

An exploratory search was conducted on PubMed using different combinations of terms related to health practitioner regulation (Table A1). No language limitations were set, though most articles retrieved were in English. Supplementary materials were identified using snowballing techniques, backward citation searching, hand searches in Google, searches in official websites of regulatory authorities in selective countries, and WHO's normative documents. These were supplemented with additional resource materials from experts.

The search retrieved 2351 sources. Peer-reviewed and grey literature, reports, legislations and articles published in English between January 2010 and June 2020 were included. Papers published before 2010 and opinion papers were excluded.

In all, 270 documents were short-listed for full-text analysis. The contents included predominantly descriptive evidence of different contexts, policy analyses and syntheses of evidence. The literature from Australia, Canada, New Zealand, the United Kingdom and the United States was dominant while those from LMICs was limited. The papers included in the analysis were reviewed by two people to identify major themes which were synthesized in narrative form. Detailed data extraction of findings of individual papers was not performed because the intent of the review was to identify a framework to commission a systematic review.

Table A1.

Search terms for the scoping review

Health practitioner Health professional Health worker Medical Nursing Allied health worker Traditional health worker Informal practitioner	Education Practice	Regulation Regulatory Regulator Council Licensing Registration Scope of practice Credentialling Accreditation Complaints	System Legislation/law/act Reform Mechanism Quality Cost Access Impact COVID-19/emergency Economic analysis Policy analysis

Summary of research methods used in the integrative review

The overarching question addressed in the review was:

What key considerations, common principles and core elements (models, approaches, tools) can countries adopt to design and deliver more effective health practitioner regulatory systems, to improve the safety, quality, quantity, capability and effectiveness of their health workforces and to achieve health system goals?

The research team developed a modified Donabedian conceptual framework (Fig. A1) to guide the review *(1)*.

The literature review used rapid review methods owing to the lack of a common terminology for health practitioner regulation and the need to capture a range of evidence from different disciplines and jurisdictions. The review adopted an integrative approach to include a variety of qualitative and quantitative evidence, in both published and grey literature, to progressively refine and update the analytical framework.

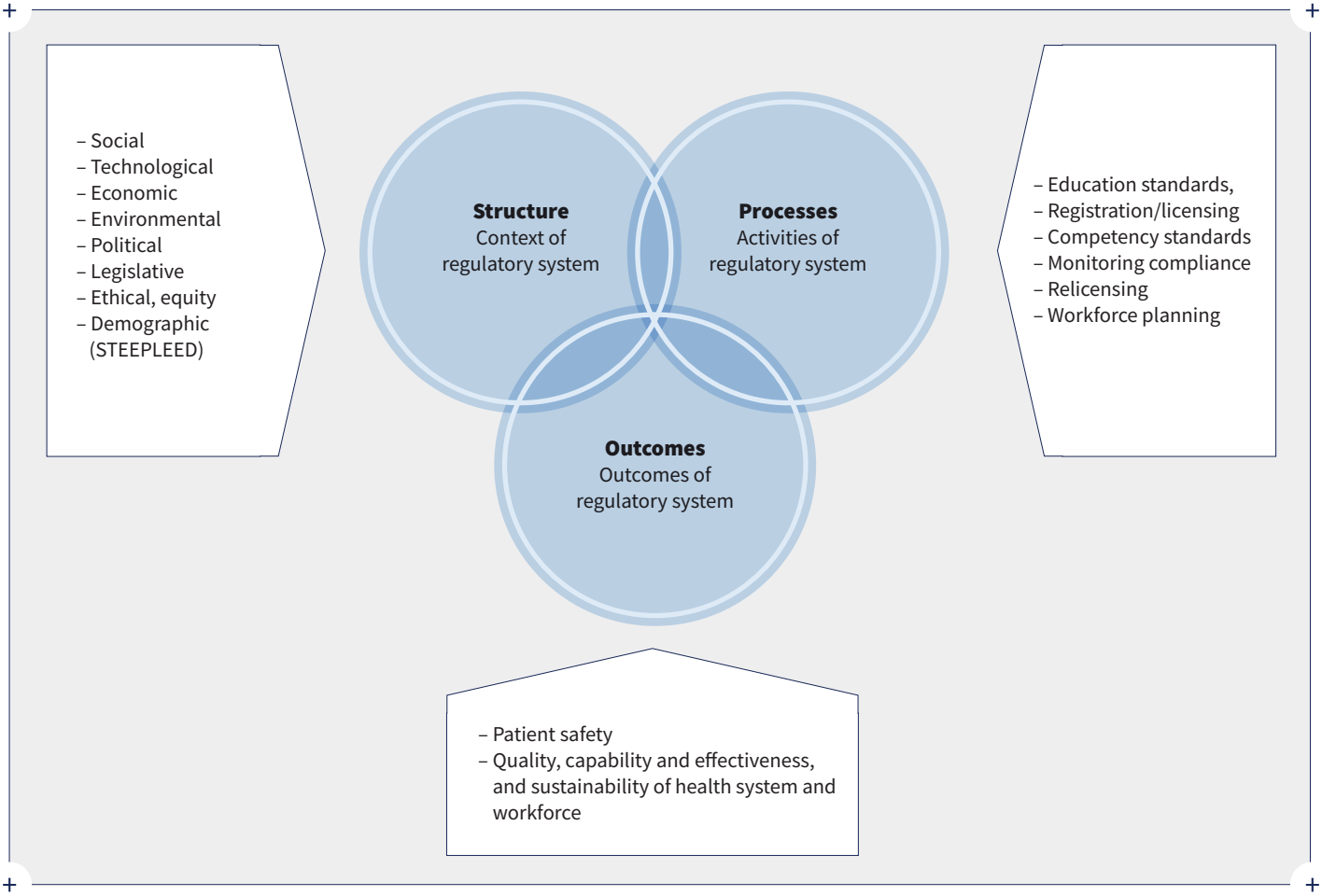
A modified population, intervention, control, outcome (PICO) framework was used to determine the scope of the review and frame the research questions. The PICO approach is primarily intended to assess the effectiveness of well-delineated clinical procedures or drugs (where the C represents the control of no intervention/no drug). This review focused on the policy and governance environment and the contents of regulation. In the modified PICO framework, the "control" was therefore replaced by "context".

Given the rarity of controlled studies on regulation and the fact that most studies did not even report quantitative outcomes, this body of evidence in the aggregate is considered of very low certainty and is not generalizable.

The two experimental studies included in the review looked at specific aspects of complaints data in two separate jurisdictions. One examined the relationship between participation in different types of continuing professional development and the incidences and types of public complaints against physicians. The other examined the prevalence and characteristics of complaint-prone doctors in private practice.

Fig. A1.

Modified Donabedian framework



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MEMORANDUM

DATE: November 1, 2024

TO: Stakeholders of the Canadian Alliance of Naturopathic Regulatory Authorities (CANRA)

FROM: Andrew Parr, CAE
Chair, Canadian Alliance of Naturopathic Regulatory Authorities

RE: Finalization and Adoption of National Entry-to-Practice Competencies for Naturopathic Doctors

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On behalf of the Canadian Alliance of Naturopathic Regulatory Authorities (CANRA), I am pleased to formally announce the successful finalization, approval, and adoption of the Canadian National Entry-to-Practice Competencies for Naturopathic Doctors. This significant achievement marks the culmination of extensive collaborative efforts and consultation across all regulated jurisdictions in Canada.

These competencies serve as the foundation for a standardized entry-to-practice benchmark that will now guide licensure requirements nationwide. This unified framework underscores our collective commitment to ensuring the highest standards of safe, competent, and ethical practice within the naturopathic profession.

The finalized competency profile is an outcome of rigorous methodological research, feedback from key stakeholders, and invaluable input from dedicated professionals across the country. With its adoption, the regulated jurisdictions can continue to confidently assess and verify the qualifications of incoming practitioners to meet these nationally recognized standards.

We extend our deepest appreciation to all stakeholders who contributed their expertise and insights throughout this process. Your input has been instrumental in shaping a competency framework that reflects both the evolving needs of the profession and the public's expectation of quality care.

You can access the finalized National Entry-to-Practice Competencies on the CANRA website located at www.canra.info. Thank you once again for your ongoing support and commitment to advancing the field of naturopathic medicine in Canada.

Warm regards,

Andrew Parr, CAE
Chair, Canadian Alliance of Naturopathic Regulatory Authorities

National Entry-to-Practice Competency Profile for Naturopathic Doctors

Overview

The practice of naturopathic medicine is regulated in Alberta, British Columbia, Manitoba, Ontario, Saskatchewan and Northwest Territories. Consistency between jurisdictions supports the workforce mobility requirements of the Canadian Free Trade Agreement. To harmonize practices and standards, the Canadian Alliance of Naturopathic Regulatory Authorities (CANRA) was formed. Its stated mission is to, "protect the integrity of naturopathic regulation by educating and unifying jurisdictions toward the collective goal of public health and safety."

In 2023, CANRA embarked on developing a national entry-to-practice Competency Profile. This Competency Profile describes the minimum expectations (i.e., professional competencies) of an individual applying for a naturopathic doctor (ND) license[1] in one of Canada's regulated jurisdictions.

These expectations are defined as "A competency is an observable ability of an individual at the point of qualification for a naturopathic doctor license integrating the necessary knowledge, skills, and judgment to ensure safe, competent, and ethical practice." The Competency Profile may be used for many purposes, including but not limited to:

- Approval of educational programs
- Providing advice/guidance to members
- Developing standards and policies
- Informing matters related to professional conduct
- Assessing applicants for entry and/or re-entry into the profession
- Constructing entry-to-practice exams and related requirements
- Determining continuing/competency education requirements

Competency Profile Development

A robust methodology based on industry best practices was used to develop the Competency Profile. A team of nine subject matter experts (practicing naturopathic doctors, educators and regulators) drawn from across the country worked to generate the

[1] Note that the College of Naturopaths of Ontario use the term Certificate of Registration. The College of Naturopathic Doctors of Alberta use the term the Practice Permit. Reference to "license" in this document is intended to encompass all registration titles used by CANRA member regulators.

associated content. Input gathered from a series of interviews with key stakeholders and relevant literature, regulations and legislation were also incorporated. The draft set of competencies was then validated via an online survey of NDs currently registered in participating jurisdictions. A Steering Committee comprised of CANRA members were responsible for overall project guidance and oversight.

Acknowledgements

The development of the competency profile could not have been realized without the contributions of a number of individuals. Great thanks are due to the Steering Committee and the team of subject matter experts for their content generation, oversight and support. The quality of this new document is due in great part to their collective efforts and generosity of time. Recognition and great appreciation are given to the 15 key informants from across Canada who participated in the focus groups. The feedback provided was extremely instructive and greatly informed the entire update process. And finally, the consultants would also like to acknowledge the contributions of the nearly 400 practising NDs who completed the online survey; your input helped to ensure that the final product is grounded in the realities of day-to-day naturopathic medicine.

Document Structure

Two types of competencies are included in the Competency Profile, key competencies and enabling competencies. High-level "Key Competencies" are defined as "the essential knowledge, skills and/or judgement required of a naturopathic doctor at entry-to-practice". In contrast, Enabling Competencies "outline the relevant knowledge and skills that contribute to the achievement of the Key Competency". Individuals must be able to demonstrate all key and enabling competencies listed herein to qualify for an ND licence.

The competency profile consists of 22 key competencies and 62 enabling competencies grouped thematically under five domains:

1. Professionalism
2. Communication
3. Assessment and Diagnosis
4. Therapeutic Management
5. Records Management

1. Professionalism

Professional standards are created to ensure a safe and therapeutic relationship between doctors, patients and other professionals. Naturopathic doctors have a responsibility to act in a professional and ethical manner which uphold regulatory standards and high-quality patient care.

Key Competencies	Enabling Competencies
1.1 Demonstrates ethical conduct and integrity in professional practice.	1.1.1 Provides care with respect and sensitivity for social and cultural identity. 1.1.2 Demonstrates **cultural safety and humility** practices in patient encounters. 1.1.3 Recognizes and addresses personal and professional **conflicts of interest**. 1.1.4 Identifies the effect of own values, beliefs and experiences in carrying out clinical activities; recognizes potential conflicts and takes action to prevent or resolve. 1.1.5 Establishes and maintains appropriate therapeutic relationships and professional boundaries with patients.
1.2 Adheres to regulatory requirements and legislation which govern the practice of Naturopathic Medicine.	1.2.1 Complies with legislation applicable to practice and adheres to professional regulations, bylaws, standards of practice, scope of practice, codes of conduct, obligations of a registrant, guidelines, and policies. 1.2.2 Understands the role of the regulatory body and the relationship of the regulatory body to one's own practice. 1.2.3 Maintains patient privacy, confidentiality, and security by complying with privacy legislation, practice standards, ethics, and policies within a clinic.
1.3 Recognizes **personal and professional limitations** and acts to resolve them.	1.3.1 Demonstrates accountability, accepts responsibility, and seeks assistance as necessary for decisions and actions within the legislated scope of practice and individual/professional competencies.
1.4 Engages in professional self-reflection and a commitment to lifelong learning.	1.4.1 Recognizes areas for professional growth and development. 1.4.2 Remains current with changing knowledge, developments, and treatments in healthcare.

2. Communication

Naturopathic Doctors are expected to develop professional relationships with their patients and other healthcare providers. Effective communication facilitates the gathering and sharing of information for both a therapeutic and competent healthcare delivery and interprofessional collaboration.

Key Competencies	Enabling Competencies
2.1 Uses oral, written and non-verbal communication effectively.	2.1.1 Demonstrates written and verbal communication skills that are clear to the recipient and appropriate to the professional context. 2.1.2 Demonstrates professional judgment in utilizing information and communication technologies in social media and advertising.
2.2 Establishes a therapeutic naturopathic doctor-patient relationship.	2.2.1 Engages in **active listening** to understand patient experience, preferences, and health goals. 2.2.2 Communicates and facilitates discussions with patients in a way that is respectful, non-judgemental, and culturally sensitive. 2.2.3 Supports the patient in their decision-making.
2.3 Develops collaborative, interprofessional relationships that optimize patient care outcomes.	2.3.1 Communicates with patients or their authorized representatives, colleagues, other health professionals, the community, the regulator, and other authorities. 2.3.2 Consults with and/or refers to other health care professionals when care is outside of scope of practice or personal competence. 2.3.3 Recognizes, respects and values the roles and responsibilities of other professionals within the health care system.
2.4 Demonstrates appropriate use of technology.	2.4.1 Maintains digital literacy to support the delivery of safe care.

3. Assessment and Diagnosis

Naturopathic doctors apply naturopathic knowledge, critical inquire, and clinical skills to analyze and synthesize information to inform assessment and diagnosis. Naturopathic doctors utilize an evidence-informed approach to provide high-quality and safe patient-centred care.

Key Competencies	Enabling Competencies
3.1 Obtains **informed consent.**	3.1.1 Clearly and accurately communicates the necessary information to obtain and document **informed consent** for all patient interactions. 3.1.2 Ensures ongoing **informed consent** is received throughout the term of care.
3.2 Completes a health history to aid in patient assessment.	3.2.1 Conducts a **patient-centered** interview to establish reason for the encounter and chief concern. 3.2.2 Collects, elicits and synthesizes clinically relevant information. 3.2.3 Identifies non-urgent health related conditions that may benefit from a referral and advises the patient accordingly. 3.2.4 Identifies urgent, emergent, and life-threatening situations, and refers the patient accordingly.
3.3 Performs a physical examination.	3.3.1 Selects relevant assessment equipment and techniques to examine the patient. 3.3.2 Determines and performs relevant physical examinations based on patient presentation and context. .
3.4 Uses diagnostic testing to aid in patient assessment.	3.4.1 Requests, orders or performs screening and diagnostic investigations. 3.4.2 Applies knowledge of naturopathic medicine to ensure accuracy of diagnostic or screening procedure(s). 3.4.3 Prepares and/or refers the patient to undergo testing. 3.4.4 Assumes responsibility for follow-up of test results.
3.5 Formulates **differential diagnoses**.	3.5.1 Integrates the patient's health history, physical examination, diagnostic results, critical thinking and clinical reasoning to formulate possible **differentials**. 3.5.2 Continues to monitor patient progression and makes refinements to the differential diagnoses.
3.6 Interprets the results of screening and diagnostic investigations using **evidence-informed clinical-reasoning.**	3.6.1 Determines if additional diagnostic procedures are required based upon the patient's diagnosis, prognosis, or response to treatment. 3.6.2 Makes appropriate referral(s) if diagnostic testing returns a critical value.
3.7 Formulates **working diagnosis**.	3.7.1 Applies **critical thinking** and **clinical reasoning** to determine a diagnosis. 3.7.2 Integrates the patient's health history, physical examination and diagnostic testing to formulate a diagnosis. 3.7.3 Determines pathogenesis and probable etiology of the diagnosis.

Key Competencies	Enabling Competencies
	3.7.4 Evaluates and amends the diagnosis, prognosis and treatment based on patient outcomes. 3.7.5 Identifies the need for additional consultation and/or referral. 3.7.6 Communicates assessment findings and diagnosis with the patient including implications for short- and long-term outcomes.

4. Therapeutic Management

Therapeutic management encompasses the scope of treatments employed by naturopathic doctors, as well as the relative risks, benefits and considerations regarding treatment options and outcomes. These include factors relating to informed consent, naturopathic principles, monitoring and reassessment. It also outlines the recognition of red flags and emergency management, as well as the protocols necessary for safe practice.

Key Competencies	Enabling Competencies
4.1 Evaluates the risk, benefit, efficacy and quality of evidence of planned procedures, interventions and treatments.	4.1.1 Identifies interactions between pharmaceutical medications and chosen therapeutic agents. 4.1.2 Demonstrates an understanding of indications and contraindications when formulating a **therapeutic plan**.
4.2 Creates, implements, and monitors a **therapeutic plan**.	4.2.1 Formulates a **therapeutic plan** based on patient's diagnosis, **determinants of health**, evidence-informed practice, patient preferences and **naturopathic principles**. 4.2.2 Implements the **therapeutic plan** using **naturopathic modalities**. 4.2.3 Schedules appropriate follow-up to monitor progress, review responses to therapeutic interventions, assess for adverse effects, and revise the **therapeutic plan** if necessary. 4.2.4 Reports adverse reactions to therapeutic substances to appropriate agencies as required by legislation.
4.3 Recognizes and manages emergency situations in the clinical setting.	4.3.1 Initiates appropriate intervention(s) for patients in an acute, emergent, or life-threatening situation. 4.3.2 Understands responsibilities and limitations in scope-of-practice when administering emergency procedures. 4.3.3 Activates emergency medical services for patients in emergent or life-threatening situations. 4.3.4 Communicates reportable diseases to the appropriate health authorities.
4.4 Ensures safety of procedures.	4.4.1 Informs the patient about planned procedure(s), including rationale, potential risks and benefits, potential adverse effects, and anticipated aftercare and follow-up. 4.4.2 Performs procedures per provincial guidelines. 4.4.3 Understands and applies safe techniques for procedures. 4.4.4 Maintains **universal precautions** and **routine practices** in infection prevention.
4.5 Practices **evidence-informed** patient care.	4.5.1 Critically appraises and applies evidence to improve patient care. 4.5.2 Demonstrates the ability to use research in clinical decision-making.

5. Records Management

Naturopathic Doctors are required to maintain and retain health records in an accurate, safe and secure manner to satisfy legal, professional and ethical obligations and to allow timely access to requested medical records.

Key Competencies	Enabling Competencies
5.1 Maintains patient records in accordance with legislation and **regulatory guidelines**.	5.1.1 Demonstrates knowledge of security, confidentiality, and access requirements for records in accordance with relevant legislation, policies, and standards. 5.1.2 Adheres to file maintenance and file transfer requirements in accordance with the standards of practice, policies, legislation and guidelines as set by the regulator.
5.2 Ensures patient records and clinical information are accurate and legible.	5.2.1 Maintains accurate and comprehensive files, data and charts. 5.2.2 Provides a reasonable means for patients to access and receive a copy of their medical records upon request.

Glossary

Cultural Safety: An outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the healthcare system and provide an environment free of racism and discrimination, where people feel safe when receiving health care. (source: https://www.canada.ca/en/health-canada/services/publications/health-system-services/chief-public-health-officer-health-professional-forum-common-definitions-cultural-safety.html)

Conflict of Interest: Where a reasonable person would conclude that a Member's/Registrant's personal, professional interest or financial interest may affect their judgment or the discharge of their duties to the patient and the patient's best interests. A conflict of interest may be real or perceived, actual, or potential, and direct or indirect.

Personal Limitations: The point at which your own knowledge, skill and judgement is no longer sufficient to provide safe, ethical competent care.

Professional Limitations: The point at which the knowledge, skill, and judgement of the profession, based on the education and training provided is no longer sufficient to provide safe, ethical, competent care.

Active Listening: The act of being fully engaged and immersed in what the other person is communicating and being an active participant in the communication process through direct on-going feedback using visual or verbal cues that the communication is being heard and understood.

Informed Consent: Informed consent is the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention. The patient must be competent to make a voluntary decision about whether to undergo the procedure or intervention.

Patient-Centered: Puts the needs, values and expressed desires of each individual patient first and above all other interests.

Differential Diagnosis/Differential(s): The process of differentiating between two or more conditions which share similar signs or symptoms (oxford dictionary) **OR** a systematic process used to identify the proper diagnosis from a set of possible competing diagnoses (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6994315/).

Working Diagnosis: The considered condition, from the list of differentials, determined to be the most probable based on current observations.

Critical Thinking: The objective analysis and evaluation of an issue in order to form a judgment. (Oxford Dictionary).

Critical Reasoning: Note: Critical reasoning seems synonymous with critical thinking, suggest changing the competency wording to “clinical reasoning”: a context-dependent way of thinking and decision making in professional practice to guide practice actions.

Therapeutic Plan: A documented plan that describes the patient's condition and procedure(s) that will be needed, detailing the treatment to be provided and expected outcome, and expected duration of the treatment prescribed by the healthcare provider. (https://medical-dictionary.thefreedictionary.com/treatment+plan)

Determinants of Health: A range of factors that influence the health status of an individual.

Naturopathic Principles: The six guiding principles which define naturopathy/naturopathic medicine.

Core Naturopathic Modalities: Central treatment therapies within the scope of practice of the naturopathic profession, as defined by the governing legislation of each jurisdiction that regulates naturopathy/naturopathic medicine.

Evidence-Informed: A process for making informed clinical decisions by integrating research evidence with clinical experience, patient values, preferences and circumstances. (Source)

Universal Precautions: The standards of practice that should be followed for the care of all patients, at all times, based on the premise that all persons are potentially infectious, even when asymptomatic.

The College of Naturopaths of Ontario	Policy Type REGISTRATION	PROGRAM POLICIES
	Title Supervision Policy	Policy No. R09.00
		Page No. 1

Intent/Purpose	To establish a policy governing the supervision of registrants by other registrants under the direction of the College of Naturopaths of Ontario (the College). This policy does not apply to the supervision of graduates of a naturopathic educational program by registrants of the College.	
Definitions	Act	Means the *Naturopathy Act, 2007*, as amended from time to time.
	Brick-and-Mortar Clinic	Means a clinic which operates in a building or other physical structure rather than over the internet.
	By-laws	Means the by-laws of the College approved by the Council under the authority of section 94 of the Code.
	Certificate of Registration	Means a document issued by the College, in the General Class, Inactive Class or emergency class, which demonstrates to the public that the holder is a registrant of the College, registered in the class set out on the certificate and identifies whether there are any terms, conditions or limitations (TCLs) placed on the certificate.
	Chief Executive Officer (CEO)	Means the individual appointed by the Council of the College pursuant to section 9(2) of the Code and who performs the duties assigned to the position of Registrar under the RHPA, the Code, the Act and the regulations made thereunder.
	College	Means the College of Naturopaths of Ontario as established under the Act and governed by the RHPA.
	Code	Means the Health Professions Procedural Code, which is Schedule 2 to the RHPA.
	Conflict of Interest	Means that as defined in section 16 of the by-laws. For the purposes of this policy, a conflict of interest between a supervisor and a supervisee exists when a prior personal or professional relationship exists.
	Council	Means the Council of the College as established pursuant to section 6 of the Act.
	Emergency Class	Means a registrant authorized to practise in Ontario, who has met the registration requirements as set in section 5.1 of the Registration Regulation.
	General Class	Means a registrant authorized to practise in Ontario, who has met the registration requirements, as set out in section 5 of the Registration Regulation.
	Inactive Class	Means a registrant not authorized to practise in Ontario, as set out in section 8 of the Registration Regulation.
	ICRC	Means the Inquires, Complaints and Reports Committee, a statutory committee of the College. Panels of this Committee are

		responsible for investigating complaints filed with the CEO regarding the conduct or actions of a registrant or to consider a report that is made by the CEO as set out in the Code.
	In Good Standing	Means the registrant's status with the College is a positive one reflecting that all of their registration fees are paid and information due to be provided to the College is complete, no other outstanding fees are on record and the individual's certificate of registration is not suspended or revoked.
	Patient Interaction	Means a patient encounter that includes, but is not limited to, an assessment and/or diagnosis, treatment and/or monitoring of a patient or patient's condition in accordance with the standards of practice of the profession.
	RHPA	Means the *Regulated Health Professions Act, 1991*.
	Register	Means an electronic, searchable database system that provides the public with information about registrants, as set out under section 23 of the Code.
	Registrant	Means an individual, as defined in section 1(1) of the Code.
	Registration Committee	Means the statutory committee of the College responsible for all registration matters referred to it by the CEO. Panels of this statutory committee are responsible for all registration matters as set out in the Code.
	Registration Regulation	Means Ontario Regulation 84/14 made under the *Naturopathy Act, 2007*.
	Supervisee	Means a registrant who, when practising the profession, is overseen by another registrant acting in the capacity of a supervisor.
	Supervisor	Means a registrant who oversees another registrant's practise of naturopathy through supervision.
	Supervision	Means the active process of directing, assigning, delegating, guiding, and monitoring an individual's performance of an activity to influence its outcome.
	Term, Condition or Limitation (TCL)	Means a term, condition, or limitation placed upon a certificate of registration which limits or restricts a registrant's activities within the practice of the profession.
General Policy	When Required	The following are circumstances when a registrant must be supervised while practising naturopathy:

		• The registrant has been issued a certificate of registration in the emergency class. • A panel of the Registration Committee has imposed a supervised practise TCL on the registrant's General class certificate of registration.
	Commencing Supervised Practise	Registrants who are required to be supervised while practising naturopathy must (a) secure one or more individuals who meet(s) the criteria as set out in this policy and who agree(s) to act as a supervisor, and (b) submit this information to the College on a form prescribed by the CEO prior to commencing, or recommencing if a prior supervision relationship was terminated, practising the profession.
	Accountability	Accountability is shared between the supervisor and the supervisee for ensuring that the supervision requirement is met, that appropriate records are maintained, that the practise of the profession abides by applicable Ontario regulations, Standards of Practice, any terms, conditions, or limitations on a supervisee's certificate of registration, and that safe and competent patient care is the priority in all patient interactions. Failure to meet the requirements may result in a referral of the matter to the ICRC by the CEO or their delegate.
	Level of Supervision	Supervisors must provide supervision which is proportionate to the supervisee's level of training, experience, knowledge, skill and judgement. Supervisors are required to assess the level of supervision needed on an on-going basis and adjust this level, based on the following factors: • The supervisee's demonstrated level of clinical readiness to safely participate in a patient's care. • The supervisee capability to safely interact with patients in circumstances where the supervisor is not present in the room. • The supervisee's demonstrated understanding of the rules and requirements for practising naturopathy.
	Termination of Supervision	Supervision must be terminated if the supervisor can no longer meet the requirements of this policy, including but not limited to the conditions for acting as a supervisor. Supervision is automatically terminated at point of expiry of a supervisee's supervised practise TCL or cessation of registration in the emergency class.
Supervisors	Qualifications	A registrant is eligible to act as a supervisor provided the following conditions are met: • holds a General class certificate of registration in good standing without any TCLs which restrict the registrant from

engaging in direct patient care or practising to the full scope of practise of the profession,

- has a minimum of three years of clinical experience as a regulated naturopath in Ontario,
- meets General class currency requirements for practising the profession as set out in s.6.(1) of the Regulation and the Registration Policy,
- is not the subject of any current disciplinary or incapacity proceeding,
- has not had a finding of professional misconduct, incompetence, or incapacity against them in the preceding three years,
- is not a member of the College's Registration Committee,
- does not hold the in-field volunteer position of examiner with the College,
- does not hold employment with the College,
- does not have any conflicts of interest with the supervisee,
- can provide in-person supervision at a brick-and-mortar clinic; and
- accepts the responsibilities of acting as a supervisor.

Responsibilities

The responsibilities of a supervisor include, but are not necessarily limited to the following:

- Conducting regular, objective assessments of a supervisee's knowledge, skill and judgement in the practise of naturopathy, and making recommendations to the supervisee with respect to additional training.
- Being immediately available, and on site, to the supervisee as needed.
- Meeting regularly with the supervisee to review patient files, discuss their assessments of patients, any care provided to them and signing off on patient records.
- Discussing any concerns arising from patient file reviews with the supervisee.
- Maintaining a detailed record of supervision and supervised activities (e.g., supervisor log) for the purposes of annual reporting and assessment reporting.
- Ensuring that supervisees are not engaging in acts or activities they are not authorized to perform or for which they have not demonstrated the necessary competency to perform.
- Supervising no more than six supervisees in total, with no more than three supervisees on any given day.
- Reporting information to the College, in the stipulated format, as required.
- Any other activities, such as reviewing other documents or obtaining feedback from the supervisee's colleagues, co-workers and staff that the supervisor deems necessary to the supervision or assessment of the supervisee's knowledge, skill and judgement.

Reporting Requirements	General	As registrants of the College, both supervisors and supervisees are required to comply with the RHPA and its regulations, the Act, the regulations made under the Act, the Standards of Practice of the Profession and the College by-laws. As such, both parties will report any instances where they believe on reasonable grounds that a breach has occurred. Furthermore, as set out in the College's Professional Misconduct Regulation, both parties must report any incidents of unsafe practise that are reasonably believed to have occurred.[1]
Supervisors	Annual Reporting	The following is reported by the supervisor to the College annually as part of registration renewal: • The name(s) and registration number(s) of the registrant(s) they have supervised within the prior 12-month period. • The location(s) in which the supervision occurred. • The controlled acts that they delegated to (a) supervisee(s) or supervised the performance of by (a) supervisee(s) within the prior 12-month period. • The number of completed supervised patient interactions undertaken by (a) supervisee(s) within the prior 12-month period. • The number of supervised practise hours within the prior 12-month period.
	Immediate Reporting	Supervisors must immediately alert the College, in writing, within two days of terminating supervision. Reporting by a supervisor does not mitigate the obligations of supervisees to also report changes to the College as required in the by-laws.
	Assessment Reports	In addition to the above, supervisors can at any point during, or at close of a supervision be requested to provide the College with an assessment report, in a format stipulated by the College, to assist the College in evaluating the supervisee's knowledge, skill and judgement in the practise of naturopathy.
Supervisees	Annual Reporting	The following is reported by the supervisee to the College annually at point of registration renewal: • The name(s) and registration number(s) of the registrants who have supervised their practise of the profession within the prior 12-month period. • The location(s) in which the supervised practise occurred. • The number of supervised patient interactions performed and the number of hours of practice for each supervisee within the prior 12-month period. • The controlled acts they have performed under supervision or delegation within the prior 12-month period.

[1] Subsection 1.(34) of Ontario Regulation 17/14 (Professional Misconduct).

- For emergency class registrants, the name, professional designation and registration number of the delegator of any authorized controlled acts performed within the prior 12-month period in accordance with 6.1(3) of the Registration Regulation.

Immediate Reporting

Supervisees must notify the College in writing within two days of a supervisor terminating their supervision and must cease practise of the profession until a new supervisor is secured, and supervisor information is reported to, and approved by, the College.

The College of Naturopaths of Ontario	Policy Type REGISTRATION	PROGRAM POLICIES
	Title Opening and Closing the Emergency Class	Policy No. R10.00
		Page No. 1

Intent/Purpose	To establish a policy which sets out the circumstances under which the Registration Committee would ask the Council of the College of Naturopaths of Ontario (the College) to allow the College to issue certificates of registration in the emergency class.	
Definitions	Act	Means the *Naturopathy Act, 2007*.
	By-laws	Means the by-laws of the College approved by the Council under the authority of section 94 of the Code.
	Certificate of Registration	Means a document issued by the College, in the General class, emergency class or Inactive class, which demonstrates to the public that the holder is a registrant of the College, registered in the class set out on the certificate and identifies whether there are any terms, conditions or limitations (TCLs) placed on the certificate.
	Chief Executive Officer (CEO)	Means the individual appointed by the Council of the College pursuant to section 9(2) of the Code and who performs the duties assigned to the position of Registrar under the RHPA, the Code, the Act and the regulations made thereunder.
	College	Means the College of Naturopaths of Ontario as established under the Act and governed by the RHPA.
	Code	Means the Health Professions Procedural Code, which is Schedule 2 to the RHPA.
	Council	Means the Council of the College as established pursuant to section 6 of the Act.
	Emergency Class	Means a registrant authorized to practise in Ontario, who has met the registration requirements as set in section 5.1 of the Registration Regulation.
	Minister	Means the Minister of Health (Ontario).
	RHPA	Means the *Regulated Health Professions Act, 1991*.
	Registration Committee	Means the statutory committee of the College responsible for all registration matters referred to it by the CEO. Panels of this statutory committee are responsible for all registration matters as set out in the Code.
	Registration Regulation	Means Ontario Regulation 84/14.

DATE APPROVED		DATE LAST REVISED

The College of Naturopaths of Ontario	Policy Type REGISTRATION	PROGRAM POLICIES
	Title Opening and Closing the Emergency Class	Policy No. R10.00
		Page No. 2

General	Legislative Authority	Paragraph 1 of subsection 5.1 of the Registration Regulation establishes that the Minister can request that the College initiate the issuance of certificates of registration in the emergency class based on their opinion that there are emergency circumstances that warrant doing so. This emergency class provision also delegates the same authority to Council, whereby it "must have determined, after taking into account all of the relevant circumstances that impact the ability of applicants to meet the ordinary registration requirements, that there are emergency circumstances, and that it is in the public interest that the College issue emergency certificates." In drafting these provisions, the Council's intention was that in order for it to open registration into the emergency Class, it would first receive a request from the Registration Committee.
Emergency Circumstances	Opening the Emergency Class	In order for the Registration Committee to ask the Council to open registration in the emergency class, it must be satisfied that such action is in the public interest and that one or more of the following conditions have been met with respect to emergency circumstances: • There is a current or imminent threat to provide supply of qualified naturopaths to adequately service the needs of the public. • There is a significant interruption to the College's ability, or the ability of a College recognized exam provider, to administer entry to practise examinations, which warrants immediate regulatory intervention. • The College has considered and ruled out all known potential solutions and issuing certificates under the emergency class is the best solution based on the circumstances.
	Continuous Assessment	Once registration in the emergency class has been opened, College staff will monitor the situation and provide regular updates to the Registration Committee and the Council. An assessment of the emergency circumstances will be made at each Council meetings while the emergency class is open.
	Closing the Emergency Class	If the Council determines that the circumstances that led to the opening of the emergency class of registration are no longer in effect, the Council will pass a motion directing the CEO to cease issuing

emergency class certificates of registration.

In compliance with section 10.2(3) of the Registration Regulation, all emergency class certificates will expire six months after the date of this motion. Once closed, new applications for an emergency class certificate will not be processed and College staff will manage the transition of existing emergency class certificate holders in accordance with 10.1 of the Registration Regulation.

The College of Naturopaths of Ontario

Conflict of Interest
Summary of Council Members Declarations 2024-2025

Each year, the Council members are required to complete an annual Conflict of Interest Declaration that identify where real or perceived conflicts of interest may arise.

As set out in the College by-laws, a conflict of interest is:

> ***16.01 Definition***
> For the purposes of this article, a conflict of interest exists where a reasonable person would conclude that a Council or Committee member's personal or financial interest may affect their judgment or the discharge of their duties to the College. A conflict of interest may be real or perceived, actual or potential, and direct or indirect.

Using an Annual Declaration Form, the College canvasses Council members about the potential for conflict in four areas:

Based on positions to which they are elected or appointed;
Based on interests or entities that they own or possess;
Based on interests from which they receive financial compensation or benefit;
Based on any existing relationships that could compromise their judgement or decision-making.

The following potential conflicts have been declared by the Council members for the period April 1, 2024 to March 31, 2025.

Elected or Appointed Positions

Council Member	Interest	Explanation
Dr. Amy Dobbie, ND	City Councilor (Family Member)	Father is an elected city councilor for the City of Quinte West. Does not believe it is a conflict – made a note of it in case.

Interests or Entities Owned

Council Member	Interest	Explanation
Dr. Brenda Lessard-Rhead, ND (inactive)	Partner of BRB CE Group	I am a partner of the business BRB CE Group, which provides continuing education courses for Naturopathic Doctors, through live conferences as well as online recorded webinars and audio recordings.

Interests from which they receive Financial Compensation

Council Member	Interest	Explanation
None		

Existing Relationships

Council Member	Interest	Explanation
None		

Council Members

The following is a list of Council members for the 2024-25 year and the date the took office for this program year[1], the date they filed their Annual Conflict of Interest Declaration form and whether any conflict of interest declarations were made.

Council Member	Date Assumed Office	Date Declaration Received	Any Declarations Made
Dr. Felicia Assenza, ND	May 29, 2024	July 9, 2024	None
Dean Catherwood	May 29, 2024	July 8, 2024	None
Dr. Amy Dobbie, ND	May 29, 2024	July 5, 2024	Yes
Brook Dyson	May 29, 2024	July 8, 2024	None
Lisa Fenton	May 29, 2024	July 5, 2024	None
Sarah Griffiths-Savolaine	May 29, 2024	Sept 24, 2024	None
Dr. Brenda Lessard-Rhead, ND (Inactive)	May 29, 2024	July 5, 2024	Yes
Dr. Denis Marier	May 29, 2024	July 5, 2024	None
Paul Philion	May 29, 2024	July 5, 2024	None
Dr. Jacob Scheer, ND	May 29, 2024	July 5, 2024	None
Dr. Jordan Sokoloski, ND	May 29, 2024	July 8, 2024	None
Dr. Erin Walsh (Psota), ND	May 29, 2024	July 5, 2024	None

A copy of each Council members' Annual Declaration Form is available here on the College's website.

Updated: September 26, 2024

[1] Each year, the Council begins anew in May at its first Council meeting. This date will typically be the date of the first Council meeting in the cycle unless the individual was elected or appointed.

The College of Naturopaths of Ontario

Report from the Council Chair
Period of September 1, 2024 to October 31, 2024

This is the third Chair's Report of six for the current Council cycle and provides information for the period from September 1, 2024 to October 31, 2024.

In September, Andrew and I met with the OAND CEO Christine Charnock and Board Chair Dr. Audrey Sasson, ND. Along with providing general organizational updates, we spoke about and responded to questions related to current consultations as well as the Terms of Reference for the Working Group on the Identification and Mitigation of Patient Harm. Our next meeting will be in January.

Andrew and I continue to meet on a monthly basis. I am pleased to be joining him on the Board of Directors for CANRA, commencing a 3-year term.

Wishing you all an enjoyable end to 2024 and all the best for the coming year.

Respectfully submitted,

Dr. Jordan Sokoloski, ND
Council Chair
18 November 2024

The College of Naturopaths of Ontario

REGULATORY OPERATIONS REPORT
HIGHLIGHTS

The Regulatory Operations Report provides data for the period of April 1, 2024, to October 31, 2024, inclusive, with an emphasis on data changes that occurred since the last reporting period (i.e., data for September and October 2024). Please note that not every section of the full report is discussed below but only those areas which are believed to be of importance to highlight for the Council.

1.1 Registration

As is the norm for this timeframe, the overall number of registrants has remained stable since the last report. Given we are beyond the renewal period, the changes typically seen relate to suspensions for failure to provide insurance renewal or CPR renewal information.

1.2 Entry-to-Practice

During September and October, 17 new applications for initial registration were received and four certificates were issued. There are currently 17 on-going applications in process. One application was referred to the Registration Committee which the Committee addressed in September.

1.3 Examinations

Three examination sittings were held in September and October, the Biomedical Examination and the Clinical (Practical) Examinations for entry to practise and the post-registration Prescribing & Therapeutics Examination respectively. For entry to practise, given that most of the College examination candidates are graduates of CCNM and given that they graduate in May, the examination numbers establish a pattern whereby most graduates sit the Clinical (Practical), followed by the written Clinical Sciences and finally the Biomedical examination.

One exam appeal was received relating to the Biomedical Examination. That appeal remains on-going.

1.5 Quality Assurance

Of interest from the Quality Assurance Program are the number of Quality Assurance Committee ordered Peer & Practice Assessments of which there have been 19 since the beginning of July. The majority of these ordered assessments would arise out of the Registration Program audit of currency hours.

1.7 Complaints and Reports

<u>Complaint and Reports Data</u>

In September and October, one new complaints was received and no new reports were initiated. One complaint and one report from earlier periods were closed.
There were no referrals to either the Discipline or Fitness to Practice Committees and there are presently 29 ongoing matters before the ICRC.

Interim Orders
The ICRC did not impose any interim orders in September and October 2024; however, two such orders remain in place from the prior years.

1.9 Hearings

There are presently two ongoing matters before panels of the Discipline Committee, both are contested hearings that began in the prior fiscal year. Although they were issued after the close of this reporting period, it is important to note that in November, both panels issued their Decision & Reasons on the allegations as set out in the Notice of Hearing for both matters. In both cases, the panels independently determined that the challenges that the College infringed on the rights of the registrants as set out in the Charter of Rights and Freedoms had no merit. Both panels independently found that the Registrants had committed acts of professional misconduct as set out in the Notices of Hearing.

Although the allegations portion of these matters are concluded, there remains hearings on penalty and on costs that remain.

1.10 Regulatory Guidance and Education

Regulatory Guidance
In September and October, regulatory guidance inquiries remained on par with prior months. For the year, the top three inquiries continue to relate to scope of practice, telepractice and fees and billing.

Regulatory Education
There were no Regulatory Education Program sessions held in September and October. With respect to the recorded sessions, we continued to see a large number of registrations in September, likely due to the deadline for submission of CE logs at the end of that month.

Respectfully submitted,

Andrew Parr, CAE
Chief Executive Officer
November 2024

The College of Naturopaths of Ontario

Report on Regulatory Operations

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
1.1 Regulatory Activity: Registration													
Registrants (Total)													**1886**
General Class (Total)													**1680**
In Good Standing	*8*	*15*	*0*	*-7*	*0*	*-1*	*0*						*1667*
Suspended	*-1*	*-2*	*0*	*0*	*0*	*0*	*1*						*13*
Inactive Class (Total)													**178**
In Good Standing	*-1*	*-7*	*1*	*6*	*1*	*4*	*0*						*168*
Suspended	*1*	*2*	*0*	*0*	*0*	*0*	*-1*						*10*
Emergency Class (Total)													***0***
In Good Standing	*0*	*0*	*0*	*0*	*0*	*0*	*0*						*0*
Suspended	*0*	*0*	*0*	*0*	*0*	*0*	*0*						*0*
Life Registrants													*28*
In Good Standing	*0*	*0*	*0*	*0*	*0*	*0*	*0*						*28*
Suspended	0	0	0	0	0	0	0						*0*

Changes in Registration Status Processed (Total)													**77**
Suspensions	21	7	1	1	0	0	2						32
Resignations	1	0	1	2	0	0	0						4
Revocations	0	6	0	0	0	0	0						6
Reinstatements	19	1	1	1	0	0	0						22
Class Changes (Total)													13
General Class to Inactive Class	0	0	1	6	1	4	0						12
Inactive Class to General Class	0	0	0	0	0	1	0						1
Any Class to Life Registrant Status	0	0	0	0	0	0	0						0
Emergency Class to General Class	0	0	0	0	0	0	0						0

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
Professional Corporations (Total)													**135**
New applications approved	1	1	2	2	0	2	1						9
Resigned/Desolved	0	0	0	1	0	0	0						1
Revoked	0	0	0	0	0	0	0						0
PC Renewals in 2024-25													
Not Yet Renewed in this period													64
Renewed	7	8	11	9	8	10	7						60
Revoked	0	0	0	0	0	0	0						0
Resigned/Dissolved	0	1	0	1	0	0	0						2

1.2 Regulatory Activity: Entry-to-Practise													
Total ETP Applications On-Going													**17**
New applications received	15	1	3	1	2	1	16						39
Certificates issued	8	16	2	1	2	2	2						33
Applications Currently before the Registration Committee													**0**
New referrals	0	0	1	1	0	1	0						3
Decisions Issued	0	0	1	1	0	1	0						3
Registration Committee Outcomes													**3**
Approved	0	0	1	1	0	0	0						2
Approved – TCLs	0	0	0	0	0	0	0						0
Approved – Exams required	0	0	0	0	0	0	0						0
Approved – Education required	0	0	0	0	0	1	0						1
Denied	0	0	0	0	0	0	0						0

Prior Learning and Recognition Program Activities in Process													**1**
New applications received	0	0	0	0	0	0	0						0
Decisions rendered on applications	0	0	0	0	0	0	0						0

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
1.3 Regulatory Activity: Examinations													
Examinations Conducted													
Ontario Clinical Sciences Examination													
Exam sittings scheduled	0	0	0	0	1	0	0						1
Exam sittings held	0	0	0	0	1	0	0						1
Number of candidates sitting exam	0	0	0	0	87	0	0						87
Ontario Biomedical Examination													
Exam sittings scheduled	0	0	0	0	0	1	0						1
Exam sittings held	0	0	0	0	0	1	0						1
Number of candidates sitting exam	0	0	0	0	0	87	0						87
Ontario Clinical Practical Examination													
Exam sittings scheduled	0	0	0	1	0	0	1						2
Exam sittings held	0	0	0	1	0	0	1						2
Number of candidates sitting exam	0	0	0	69	0	0	35						104
Ontario Therapeutic Prescribing Examination													
Exam sittings scheduled	1	0	0	0	0	1	0						2
Exam sittings held	1	0	0	0	0	1	0						2
Number of candidates sitting exam	47	0	0	0	0	48	0						95
Ontario Intravenous Infusion Examination													
Exam sittings scheduled	0	1	0	0	0	0	0						1
Exam sittings held	0	1	0	0	0	0	0						1
Number of candidates sitting exam	0	19	0	0	0	0	0						19
Examination Appeals													
Ontario Clinical Sciences Examination Appeals (Total)													0
Appeals Filed	0	0	0	0	0	0	0						0
Appeals Granted	0	0	0	0	0	0	0						0
Appeals Denied	0	0	0	0	0	0	0						0
Ontario Biomedical Examination Appeals (Total)													2
Appeals Filed	1	0	0	0	0	0	1						2
Appeals Granted	0	0	1	0	0	0	0						1
Appeals Denied	0	0	0	0	0	0	0						0
Ontario Clinical Practical Examination Appeals (Total)													0
Appeals Filed	0	0	0	0	0	0	0						0
Appeals Granted	0	0	0	0	0	0	0						0
Appeals Denied	0	0	0	0	0	0	0						0

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
0ntario Therapeutic Prescribing Examination													0
Appeals Filed	0	0	0	0	0	0	0						0
Appeals Granted	0	0	0	0	0	0	0						0
Appeals Denied	0	0	0	0	0	0	0						0
Ontario Intravenous Infusion Examination Appeals (Total)													0
Appeals Filed	0	0	0	0	0	0	0						0
Appeals Granted	0	0	0	0	0	0	0						0
Appeals Denied	0	0	0	0	0	0	0						0

Exam Questions Developed (Total)													**178**
CSE questions developed	0	104	0	0	0	0	0						104
BME questions developed	0	0	0	74	0	0	0						74

1.4 Regulatory Activity: Patient Relations													
Funding applications													
New applications Received													0
Funding application approved	0	0	0	0	0	0	0						0
Funding applilcation declined	0	0	0	0	0	0	0						0
Number of Active Files													**1**
Funding Provided	$0	$1560	400	$710	$461	$0	$560						$3,691

1.5 Regulatory Activity: Quality Assurance													
Peer & Practice Assessments (Remaining for Year)													58
Pool selected by QAC													150
Deferred, moved to inactive or retired (removed from	0	-3	-4	0	-1	0	0						-8
Assessments ordered by QAC, i.e. outside of random pool	1	0	0	7	6	5	1						20
Total Number of Assessment for the Year.													162
Completed (Y-T-D)	1	0	0	1	16	30	56						104

Quality Assurance Committee Reviews													
Assessments reviewed by Committee	0	0	0	0	1	0	2						**6**
Satisfactory Outcome	1	0	0	0	0	0	2						3
Ordered Outcome (SCERP, TCL, etc.)	2	0	0	0	1	0	0						3

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
CE Reporting													
Number in group	0	0	0	0	0	530	0						530
Number received	0	0	0	0	0	519	11						530
Number of CE Reports with deficiencies	0	0	0	0	0	0	73						
QAC Referrals to ICRC	0	0	1	0	0								1
1.6 Regulatory Activity: Inspection Program													
Registered Premises (Total Current)													**164**
Total Registered from prior year (as of May 1)													158
Newly registered	5	0	2	0	3	2	0						12
De-registered	3	1	0	0	1	0	1						6
Inspections of Premises													
New Premises													
Part I Completed	4	1	2	2	1	3	0						13
Part II Completed	1	2	2	0	0	0	3						8
5-year Anniversary Inspections													
Premises requiring 5-year inspection													17
Completed	0	0	1	0	1	1	2						5
Inspection Outcomes													
New premises-outcomes (Parts I & II)													
Passed	3	4	3	0	4	5	0						19
Pass with conditions	4	1	3	0	2	0	0						10
Failed	0	0	0	0	0	0	0						0
5-year Anniversary Inspection Outcomes													
Passed	2	0	0	0	0	1	0						3
Pass with conditions	1	1	0	0	2	2	0						6
Failed	0	0	0	0	0	0	0						0

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
Type 1 Occurrence Reports (Total Reported)													**10**
Patient referred to emergency	0	1	1	1	1	2	2						8
Patient died	0	0	0	0	0	0	0						0
Emergency drug administered	0	1	1	0	0	0	0						2
Type 2 Occurrence Reports (Outstanding)													**0**
Total Reports Required to be filed.	0												168
Reports Received	149	19	0	0	0	0	0						168
1.7 Regulatory Activity: Complaints and Reports													
Complaints and Reports (Total On-going)													**29**
Complaints carried forward from prior period(s)													13
Reports carried forward from prior period(s)													5
New Complaints	2	4	0	3	1	0	1						11
New Reports	0	2	0	1	1	0	0						4
Matters returned by HPARB	0	0	0	0	0	0	0						0
Complaints completed	3	1	0	2	1	1	0						8
Reports completed	1	0	1	1	0	1	0						4
Files in Alternate Dispute Resolution (In process)													**0**
ADR Files from Prior Period													1
New files referred to ADR	0	0	0	0	0	0	0						0
Files resolved at ADR	1	0	0	0	0	0	0						1
ICRC Outcomes (files may have multiple outcomes)													
Take no further action	0	0	0	0	1	0	0						1
Letter of Counsel	0	1	0	1	0	0	0						2
Oral Caution	0	0	0	3	0	0	0						3
Specified Continuing Education and Remediation	3	0	0	0	0	0	0						3
Letter of Counsel & SCERP	0	0	0	0	0	1	0						1
Oral Caution & SCERP	0	0	1	0	0	1	0						2
Acknowledgement & Undertaking	0	0	0	2	0	0	0						2
Referral to Fitness to Practise Committee	0	0	0	0	0	0	0						0
Referral to Discipline Committee	0	0	0	0	0	0	0						0
Frivolous & Vexatious	0	0	0	0	0	0	0						0
Resolved through ADR	1	0	0	0	0	0	0						1
Withdrawn by Complainant	0	0	0	0	0	0	0						0

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
Interim Orders (Currently In Place)													**2**
Orders issued in prior period													2
New Interim Orders - TCLs Applied	0	0	0	0	0	0	0						0
New Interim Orders - Suspended	0	0	0	0	0	0	0						0
Interim Orders Removed	0	0	0	0	0	0	0						0
Summary of concerns (files may have multiple concerns)													
Advertising/Social Media	0	1	0	1	1	0	0						3
Billing and Fees	1	0	0	0	0	0	1						2
Communication	0	0	0	1	0	0	1						2
Competence/Patient Care	2	2	0	3	1	0	0						8
Fraud	0	0	0	0	0	0	0						0
Professional Conduct & behaviour	0	1	0	1	0	0	0						2
Record Keeping	0	0	0	0	0	0	0						0
Sexual Abuse/Harassment/Professional Boundaries	0	0	0	1	0	0	0						1
Delegation	0	0	0	0	0	0	0						0
Unauthorized Practice/Scope of Practice	0	3	0	0	1	0	0						4
Failure to comply with an Order	0	0	0	0	0	0	0						0
Inappropriate/ineffective treatment	0	0	0	0	0	0	0						0
Conflict of Interest	0	0	0	0	0	0	0						0
Lab Testing	0	0	0	0	0	0	0						0
QA Program Compliance	0	0	0	0	1	0	0						1
Cease & Desist Compliance	0	0	0	0	0	0	0						0
Failure to Cooperate	0	0	0	0	0	0	0						0
Practising while Suspended	0	0	0	0	0	0	0						0
Unprofessional/Unbecoming Conduct	0	0	0	0	0	0	0						0
Other	0	0	0	0	0	0	0						0
1.8 Regulatory Activity: Unauthorized Practitioners													
Cease and Desist Letters (Unsigned/Outstanding)													**7**
Letters Outstanding from Prior Period													3
Letters Issued	2	2	1	0	1	1	0						7
Letters signed back by practitioner	1	1	1	0	0	0	0						3

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
Injunctions from Court													
Injunctions in place from prior year													2
Applications Outstanding from prior year	-1												0
New Applications Filed	0	0	0	0	0	0	0						0
Applications approved by the Court	1	0	0	0	0	0	0						1
Applications denied by the Court	0	0	0	0	0	0	0						0
1.9 Regulatory Activity: Hearings													
Matters Referred by ICRC													
Referrals to the Discipline Committee (Total)													**2**
Referrals from prior period													2
New referrals	0	0	0	0	0	0	0						0
Matters concluded	0	0	0	0	0	0	0						0
Referrals to the Fitness to Practise Committee (Total)													**0**
Referrals from prior period													0
New referrals	0	0	0	0	0	0	0						0
Matters concluded	0	0	0	0	0	0	0						0
Disciplinary Matters													
Pre-hearing conferences													
Outstanding from prior year													0
Scheduled	0	0	0	0	0	0	0						0
Completed	0	0	0	0	0	0	0						0
Discipline hearings													
Ongoing from Prior Year													2
Contested hearing completed	0	0	0	0	0	0	0						0
Uncontested heartings completed	0	0	0	0	0	0	0						0
Outcomes of Contested Matters													
Findings made	0	0	0	0	0	0	0						0
No findings made	0	0	0	0	0	0	0						0
FTP Hearings													
Finding of incapacitated	0	0	0	0	0	0	0						0
No finding made	0	0	0	0	0	0	0						0

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
1.10 Regulatory Activity: Regulatory Guidance & Education													
Regulatory Guidance													
Inquiries Received (Total)													**385**
E-mail	33	39	26	38	24	28	30						218
Telephone	16	41	31	21	14	22	22						167
Most Common Topics of Inquiries													
Telepractice	3	11	4	5	4	3	2						**32**
Record Keeping	1	7	5	6	3	3	3						28
Scope of Practice	4	11	8	5	3	5	1						**37**
Injections	1	3	3	2	2	0	2						13
Patient Visits	0	1	0	4	1	3	1						10
Delegations and Referrals	5	6	4	4	2	2	1						24
Laboratory Testing	4	3	1	3	3	3	4						21
Consent and Privacy	5	3	1	2	1	1	3						16
Conflict of Interest	1	1	2	2	1	1	3						11
Prescribing	1	0	2	5	2	2	4						16
Fees and Billing	1	4	9	5	6	6	4						**35**
Inspection Program	4	2	3	1	0	3	1						14
Endorsements	0	1	0	1	0	2	1						5
Graduates working for NDs	3	3	0	0	0	1	0						7
Continuing Education	1	2	0	0	3	3	2						11
Advertising	1	6	7	0	0	1	1						16
Notifying Patients when Moving	3	1	0	1	0	1	0						6
Completing Forms and Letters for Patients	1	1	0	2	1	0	2						7
Registration and CPR	0	4	0	1	1	3	1						10

Regulatory Education Program													
Live Sessions													
Session Delivered	1	1	1	1	1	0	0						5
Registrations	252	302	236	321	309	0	0						1420
Attendees	164	202	161	206	195	0	0						928
Recorded Sessions													
Registrations	16	14	41	150	146	202	16						585

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
1.11 Regulatory Activity: HPARB Appeals													
Registration Committee Decisions before HPARB													**0**
Appeals carried forward from prior period													0
New appeals filed with HPARB	0	0	0	0	0	0	0						0
Files where HPARB rendered decision	0	0	0	0	0	0	0						0
HPARB Decisions on RC Matters													
Upheld	0	0	0	0	0	0	0						0
Returned	0	0	0	0	0	0	0						0
Overturned	0	0	0	0	0	0	0						0
ICRC Decisions before HPARB (Total current)													**5**
Appeals carried forward from prior period													3
New appeals filed with HPARB	2	0	0	0	0	0	0						2
Files where HPARB rendered decision	0	0	0	0	0	0	0						0
HPARB Decisions on ICRC Matters													
Upheld	0	0	0	0	0	0	0						0
Returned	0	0	0	0	0	0	0						0
Overturned	0	0	0	0	0	0	0						0

Regulatory Activity	April '24	May '24	Jun '24	Jul '24	Aug '24	Sep '24	Oct	Nov	Dec	Jan '25	Feb	Mar '25	YTD
1.12 Regulatory Activity: HRTO Matters													
Matters filed against the College													
Matters in progress from prior period(s)													1
New matters	0	0	0	0	0	0	0						0
Matters where HRTO rendered a decision	0	0	0	0	0	0	0						0
HRTO Decisions on Matters													
In favour of applicant	0	0	0	0	0	0	0						0
In favour of College	0	0	0	0	0	0	0						0

Report on Operations – Mid-Year

APRIL 1, 2023 TO MARCH 31, 2027

Activity	Key Performance Indicators

I. INTRODUCTION TO THE OPERATIONAL PLAN FOR 2023-2027

The current four years of operations have been realigned and re-prioritized to match the Council's new Strategic Plan and Ends Statements. Much of what the College does is set out in the legislative framework governing the College and the profession. These continue to be reflected in this operational plan given the substantial financial and human resources required to meet these obligations.

Unlike the Operational Plan of the last several years, this plan is organized within the strategic objectives and priorities established by the Council. This is intended to allow the Council and the reader to understand which initiatives being undertaken are supporting which objectives and priorities. It is acknowledged that some initiatives may support more than one strategic priority. While this will be noted, the initiatives will be set out only one time and in the area where it is identified as the major operational priority.

We will continue to focus on excellence in regulation, ensuring we fulfill our core mandate to protect the public, and oversee the practice of naturopathy. Operations will focus on ensuring we clearly define our goals, and evaluate our progress, and success in achieving them. Very specific initiatives have been identified to meet the challenges identified above.

II. STRATEGIC OBJECTIVES AND PRIORITIES OF THE COUNCIL

On January 25, 2023, the Council approved its Strategic Plan and Ends Statements. These are as follows:

Objective 1: The College engages its stakeholders, through education and collaboration, to ensure that they understand the role of the College and trust in its ability to perform its role.

Related priorities:
1. The College engages its system partners to further their understanding and trust in the College and the profession.

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

2. The College engages its registrants and the public to further their understanding and trust in the College and the profession.
3. The College relies on a risk-based approach to proactively regulate the profession.

Objective 2: Naturopathic Doctors are trusted because they are effectively regulated.

Related priorities:

1. Applicants are evaluated based on their competence and evaluations are relevant, fair, objective, impartial and free of bias and discrimination.
2. Registrants and the public are aware of and adhere to the standards by which NDs are governed.
3. Registrants are held accountable for their decisions and actions.
4. Registrants maintain their competence as a means of assuring the public that they will receive safe, competent, ethical care.
5. The College examines the regulatory model to maximize the public protection benefit to Ontarians.

Each of the priorities has been numbered for ease of reference. The numbers are intended to reflect the order the Council has laid them and are not indicative of priorities within the objectives.

III. PURPOSEFUL ENGAGEMENT OF STAKEHOLDERS

The Council's first of two overall objectives it has established is that the College will engage, through collaboration and education, its stakeholders and will do so with purpose. The stated purpose is to ensure that they understand the role of the College and trust the College to perform its regulatory role. It specifically states:

1. The College engages its stakeholders, through education and collaboration, to ensure that they understand the role of the College and trust in its ability to perform its role.

The following operational activities will be undertaken in support of this objective and its related priorities.

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

1.1	**The College engages its system partners to further their understanding and trust in the College and the profession.**

The College's systems partners will include the Ministry of Health (MOH), Ontario Association of Naturopathic Doctors (OAND), the Canadian College of Naturopathic Medicine (CCNM), Health Professions Regulators of Ontario (HPRO), and Canadian Alliance of Naturopathic Regulatory Authorities (CANRA). The relationship with each system partner will be unique such that one approach will not fit all. Two activities will be undertaken in support of this priority. The overall focus of this priority is to provide education and collaboration opportunities.

1.1.1	Individualized System Partner Engagement							
The College will engage with each of its system partners on a regularized basis as an opportunity to discuss issues of mutual concern or importance within the regulatory system.					• Meetings will be scheduled with each system partner at a frequency and timing that meets the needs of each partner and the College. • The College will oversee the process of scheduling, agenda development, meeting minutes (where agreed upon) and development of meeting highlights to be released for transparency purposes. Each agenda will be focused on education of each stakeholder by each stakeholder and seeking opportunities to collaborate in the broader public interest.			
Timeframe:	All 4 Planning Years				**Responsible:**	Chief Executive Officer		
Year-to-date outcomes:	Several discussions have been held with the Ministry of Health on a variety of questions surrounding drug lists. Two meetings of members of the Canadian Alliance of Naturopathic Regulatory Authorities have been held during this period (April and August) and two meetings of the OAND/CoNO leadership were held (May and September).							
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒	To be deferred
Comments:								

1.1.2	System Partners' Forum
~~The College will develop and launch a System Partners' Forum where all system partners will be invited to participate and to focus on issues that are or may be arising (based on risk-based data) in the~~	~~• Meetings will be arranged a minimum of twice per year, with those who wish to attend.~~

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators
~~regulatory system with the intent of developing risk mitigating opportunities.~~	• ~~The College will oversee the process of scheduling, agenda development, meeting minutes (where agreed upon) and development of meeting highlights to be released for transparency purposes.~~
Timeframe: All 4 Planning Years	**Responsible:** Chief Executive Officer

1.2	**The College engages its registrants and the public to further their understanding and trust in the College and the profession.**

Although this priority focuses on engagement of both the registrants of the College and the public, it is intended that this engagement will focus on education and collaboration. There are a number of activities in which the College engages that will fall within this priority; however, many of these can and will be augmented to improve the overall effectiveness and impact that they have.

1.2.1	In Conversation With Program							
The College will continue to deliver its ***In Conversation With*** series, a fireside chat concept that engages both the public and registrants on key issues in regulation. This series will continue on an as needed basis to focus on key issues being faced by the College or promoting Council and volunteer opportunities.	• A minimum of one ICW event will be offered each year promoting volunteering. • Additional topics will be developed by the College in support of other programming such as consultations and governance matters.							
Timeframe: All 4 Planning Years					**Responsible:** Communications			
Year-to-date outcomes:	No In Conversation With session were held in the first half of this planning year; however, several are in the works for the latter half of the year.							
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒	To be deferred
Comments:								

1.2.2	Consultation Program

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

The College will continue to engage the public and its registrants in consultation on key issues and initiatives; however, an augmented process will be introduced that allows the public and the registrants to hear directly from the College about the intent and outcomes of the regulatory changes under consultation.	• The College will release consultation documents on significant change being proposed to the regulatory framework, albeit regulations, by-laws, Council policies. • Feedback will be sought through written and on-line opportunities. • The College will invite the public and registrants to attend information sessions about the consultation topic, through the ICW program, as an opportunity for the College to provide education and allow participants to gain a fulsome understanding of what is being proposed and to provide meaningful feedback. • The College will maintain an on-going mechanism for registrants and the Public to provide feedback with respect to the tables of permitted drugs and substances within the General Regulation so that the College can ensure that they are accurate and up-to-date and work with the Association to allow it to consider changes that may reflect a change in scope of practice.						
Timeframe:	All 4 Planning Years				**Responsible:**	Chief Executive Officer	
Year-to-date outcomes:	One formal consultation was initiated in this period relating to 19 Standards of Practice. Additional consultations are in the planning process.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

1.2.3	Regulatory Education Program						
The College will develop and maintain a new Regulatory Education Program (REP) that provides detailed education into regulatory issues and concerns. The REP will be informed both by current issues as well as by data derived from the Risk-based Regulation Program of the College.	• A minimum of six sessions will be offered on-line annually at no or minimum cost to registrants. • The Quality Assurance Committee will be asked to consider awarding continuing education credits to these sessions as appropriate.						
Timeframe:	All 4 Planning Years				**Responsible:**	Chief Executive Officer	

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Year-to-date outcomes:	A total of five REP programming sessions were delivered in the first half of the year, all of which were allocated 1 jurisprudence CE credit by the Quality Assurance Committee. The following topics were covered: • Making and Accepting a Delegation (April 2024) • Identifying and Understanding the Drugs and Substances available for Naturopathic Practice (May 2024) • The Patient Pathway with the Ministry of Health (June 2024) • Understanding Ontario's Complex Mandatory Reporting Requirements (July 2024) • Record Keeping (August 2024)						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

1.2.4	On-going Corporate Communications						
The College will maintain a program of outbound communications and messaging to registrants, public and stakeholders through defined program elements.				• Registrants and stakeholders of the College will be informed of the College's on-going work and new developments through: ○ The iNformeD e-newsletter. ○ The News sections of the College's website. ○ Accuracy and currency of the College's website. ○ The College's social media channels.			
Timeframe:	All 4 Planning Years				**Responsible:**	Communications	
Year-to-date outcomes:	Six editions of iNformeD, the College's newsletter were delivered to registrants and stakeholders. The College's website was updated regularly with 12 new pages added, 7 new articles and 9 additional resources. Approximately 159,000 visitors viewed the website and approximately 411,000 clicks within the site were encountered. The College's social media channels were updated during this period with 82 posts made to both the Facebook and LinkedIn site. Just under 3,000 visitors encountered our social media sites.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

1.3	**The College relies on a risk-based approach to proactively regulate the profession.**

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Risk-based regulation is intended to alter the regulatory landscape from one that is primarily reactive (complaint and report driven) to one that is pro-active. It is intended to use information and data from the College's regulatory activities as a means of identifying current and emerging risks to the public and to develop appropriate mechanisms (education, information, research) to mitigate those risks. Research remains conflicted in terms of specific measures that can be used from within the regulatory system; however, it is believe that an overall systemic approach will provide sufficient information to allow risks to be identified risk mitigation techniques deployed.

1.3.1	Risk-based Regulation Program Development							
The College will articulate its initial approach to Risk-based regulation and present the preliminary final concept to the Council. It is acknowledged that the approach will be an iterative one that will require refinement based on information gleaned through the processes.					• The preliminary plan will be developed and articulated in writing, including the identification of current data available to the program and new data sets required. • The Senior Management Team of the College will present the final plan to the Council no later than March 2024.			
Timeframe:	2023-2024				**Responsible:**	Chief Executive Officer		
Year-to-date outcomes:	The Risk-based Regulation Program documentation was presented and approved by Council in March 2024							
Year-to-date rating:	❒	Not started	❒	In progress	☑	Completed	❒	To be deferred
Comments:								

1.3.2	Risk-based Regulation Program Implementation		
The risk-based regulatory approach will be initiated by developing and launching the necessary mechanisms to collect and interpret the data.		• Data will be collected and assembled in raw form. • The data will be presented to the system partners for discussion and enunciation of the inherent risks to the public identified. • Appropriate mitigation techniques will be identified and delivered.	
Timeframe:	2024-2027	**Responsible:**	Chief Executive Officer
Year-to-date outcomes:	Implementation of the Risk-based Regulation program, presented to and accepted by the Council in March 2024 has been underway. Meeting with the program areas of the College that collect the necessary data have been held and processes for data collection and reporting established.		

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

	A working group has been developed, the terms of reference of which have been vetted by the GPRC and will be presented to Council in November 2024. The OAND and CCNM have both accepted invitations to participate in the working group. Follow up is underway with the Ministry of Health. Work is underway to establish the proper mechanisms for reviewing the data and the College has engaged with an external research company that presently works with several Colleges to provide patient perspective data.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

IV. EFFECTIVE REGULATION LEADS TO TRUST IN THE PROFESSION.

The Council' second of two overall objectives focuses on effective regulation of the profession with the intention that the regulation will increase the trust the public has in the profession itself. It specifically states:

2. Naturopathic Doctors are trusted because they are effectively regulated.

Although the Council has identified five priority activities in support of this strategic objective, there are a number of on-going corporate activities that are necessary in order to accomplish "**effective regulation**". For the College to regulate, it must have:

A. A functioning Council that operates under the principles of good governance.
B. A system of Committees that are properly constituted with capable individuals sitting on those committees.
C. A program that seeks out volunteers, assesses and trains volunteers how to properly perform their duties.
D. A well instituted human resource program and a human resources plan to ensure that the skills needed to operate the College are available and on a sustained basis.
E. A financial management system that ensures the College operates within generally accepted accounting principles and is using its financial resources effectively.
F. A program that supports both transparency and accountability.
G. The ability and commitment to the oversight requirements placed on the College in the public interest that allow proper and full accounting of the College.

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Each of these will be addressed prior to addressing the Council's five priority activities.

2 (A)	**Operating under the principles of good governance**

2(A)-1	Quality Decision-making							
The College will operate a program that ensures that the Council is properly equipped to make decisions on policy matters brought before it.					• Council will be fully briefed on all major issues and policy matters to be brought before it and Council will receive its materials for meetings in a timely manner. • Briefing notes on major issues and policies will be developed as needed and presented to Council to facilitate the deliberative process. • Briefings of Council will include a detailed analysis of the risk, privacy, financial, transparency, public interest and EDIB considerations of the decisions being considered.			
Timeframe:	All 4 Planning Years				**Responsible:**	Chief Executive Officer		
Year-to-date outcomes:	Council has been briefed on all major issues and policies, including: • Committee Terms of Reference, CDHO Governance Report, by-law amendments in May 2024; • Auditor's Report and Audited Financial Statements, Council evaluation for 2023-24 in July 2024; • Changes to the Organizational Structure in September 2024. All briefings have included consideration of risk, privacy, financial costs, transparency, public interest and EDIB.							
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒	To be deferred
Comments:								

2(A)-2	A Commitment to equity, diversity, inclusion and belonging

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators
The College will continue its commitment to integrate the principles of equity, diversity, inclusion and belonging into all of its activities.	• Support will be provided to the Equity, Diversity and Inclusion Committee (EDIC) to enable development and implementation of its equity tool that will be used as a means of evaluating programs, policies, and procedures etc. • By the completion of the four-year plan, the EDIC will be disbanded with individual members joining other committees where they can champion the EDIC's efforts.

Timeframe:	All 4 Planning Years	**Estimated cost:**	$3,350	**Responsible:**	Human Resources

Year-to-date outcomes:	The EDIB Committee has fully implemented the EDIB Lens Tool which has been reviewed, updated and is included in all Committee meeting packages for review and consideration. The Committee continues to seek feedback on the Lens Tool and has initiated research into best practices for the development of Land Acknowledgments						
Year-to-date rating:	❒	Not started	❒	In progress	☑	Completed	❒ To be deferred
Comments:							

2 (B)	Committees that are properly constituted with capable individuals sitting on those committees.

The College will operate a program to ensure that the College Council, and its committees are always properly constituted and therefore able to fulfill their governance obligations.	• Council elections will be delivered annually in accordance with the by-laws. • Executive Committee elections will be delivered annually, and supplemental elections held as needed, in accordance with the by-laws and Council policies. • Public member appointments will be monitored to ensure applications for renewals are submitted in a timely manner and that the Public Appointments Secretariat is aware of vacancies and the need to appointment and re-appointment as necessary.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

The College will maintain a program to ensure that Committees are properly constituted, volunteers are recruited, and appointments are sought from the Council.				• The CEO will monitor all committees to ensure that they are properly constituted as set out in the College by-laws. • Council will be presented a slate of appointments, at minimum annually at its May meeting and on-going appointments will be presented to the Council or the Executive Committee on an as-needed basis.	
Timeframe:	All 4 Planning Years	**Estimated cost:**	$193,694	**Responsible:**	Human Resources
Year-to-date outcomes:	In May 2024, the Council was presented with a slate of volunteers to be appointed to all Council Committees. These appointments ensured that the Committees were properly constituted. All volunteers were individuals who had previously been appointed or who were vetted through the Council's Qualifying program.				
Year-to-date rating:	❒ Not started	☑ In progress	❒ Completed	❒ To be deferred	
Comments:					

2 (C)	Volunteer Recruitment, Assessment and Training program.

2(C)-1	Recruitment				
The College will maintain a comprehensive volunteer program to ensure the involvement of the public and registrants in regulatory processes.				• Recruitment of volunteers from among registrants and the public will be undertaken on an on-going basis. • A retention program that will be implemented that incorporates best practices in retention including regular feedback opportunities from current volunteers and those that may exit the program. • A recognition program for volunteers will be implemented as a means of augmenting the retention of volunteers and recognizing the value that the Council and College places on its human resources.	
Timeframe:	All 4 Planning Years			**Responsible:**	Human Resources

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Year-to-date outcomes:	A total of six new volunteer applications were reviewed and approved in the first half of the reporting year as follows one Council member [see 2(C)-2], three examiners, one PLAR assessor and one volunteer who is assisting the College both as an Item Writer and as a PLAR Committee member.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2(C)-2	Competency Assessment
The College will fully implement and manage the Council's Qualifying Program for all volunteers, including those seeking election to Council and appointment to a Council Committee.	• A minimum of one orientation sessions will be delivered for potential candidates for election and individuals seeking appointment to Committees to provide an overview of their duties and responsibilities and overall time commitment. • Each volunteer will be required to complete a competency-based self-assessment based on the competencies established by the Council in its Governance Process policies. • Each volunteer will be screened by the Governance Committee to confirm their competency and overall fit with the College's volunteer program. • The Governance Committee will determine eligibility for election to the Council and make recommendations to the Council for volunteer appointments to committees.

Timeframe:	All 4 Planning Years				**Responsible:**	Human Resources	
Year-to-date outcomes:	In the first half of this reporting year a panel of the Governance Committee interviewed and recommended one nominee to Council who was elected by acclamation.						
Year-to-date rating:	❒	Not started	❒	In progress	❒	Completed	❒ To be deferred
Comments:							

2(C)-3	Training

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

The College will operate a program to ensure that all new and existing Council and Committee members are afforded the necessary training and fulfill their duties.				• A minimum of one live training session will be offered annually for new Council and committee members that sets out their duties and responsibilities surrounding due diligence, public protection and other key matters. • A minimum of one training session bi-annually or as needed for Council and committee chairs and co-chairs. • All new volunteers will be required to complete training on bias, diversity, human rights, accessibility and anti-discrimination. • All sitting Council and Committee members will be required to complete an on-line version of the training as a refresher every two years.	
Timeframe:	All 4 Planning Years	**Estimated cost:**	$13,975	**Responsible:**	Human Resources
Year-to-date outcomes:	At the time of this report, the CCDI campaign was well underway with all active volunteers (total count of 140) enrolled in two online modules: IDEA Fundamentals and Introduction to Unconscious Bias. Of those enrolled, 104 have completed the training (a completion rate of 74%). The deadline for training completion is the end of November 2024.				
Year-to-date rating:	❒ Not started	☑ In progress	❒ Completed	❒ To be deferred	
Comments:					

2 (D)	Proper Human Resource Management and a Human Resources Plan.

2(D)-1	Effective Human Resource Management

The College will manage its human resources in such a way as to recognize the value of its staff and in keeping with best practices for human resource management in the not-for-profit sector.	• The College will undertake recruitment of new personnel in a way that first emphasises current staff and is open and transparent. • College staff will be compensated in a manner that reflects the current market value of the positions. • New staff will be provided with the information and tools necessary to the performance of their duties with the College.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators
	• Staff performance will be evaluated in an open and transparent way based on standardized performance management processes. • Staff who are leaving the College will be treated with respect and dignity.
College management and staff will work collectively to continue to build and enhance the College "team" as a unified work force and to ensure that the College's workplace environment is conducive to the team approach.	• The College shall take all necessary and prudent steps to ensure that the College workplace environment promotes diversity and inclusivity, and is free from harassment, abuse, and discrimination, including annual reviews of the College's relevant policies and ensuring that proper investigations are conducted when concerns are raised. • The College shall foster a team approach through shared work and social experiences.
The College will provide staff with on-going training to enhance individual and program performance.	• The CEO will provide all staff with group training in areas of importance to the College and its regulatory work. • A formal process to support and encourage staff professional development will be established and integrated to the annual performance review process, to enhance their own performance, that of the program areas and as developmental opportunities. • The College shall maintain membership in both the Council on Licensure, Enforcement and Regulation (CLEAR) and Canadian Network of Agencies for Regulation (CNAR) and share information from these organizations with staff. • Within the budgetary restrictions, the College will send staff to the CLEAR Annual Education Conference and to the CNAR Annual Education Conference. • Processes will be implemented to assist staff in self identifying training needs related to their program area(s) and opportunities for future advancement.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Timeframe:	All 4 Planning Years				**Responsible:**	Human Resources	
Year-to-date outcomes:	In the first half of the reporting year performance appraisals for all eligible staff members were completed and two new staff retention initiatives were announced: wage step and pay for performance, which will take effect in the 2025 fiscal year. Two contract staff members were promoted to permanent positions, one new position under the College's updated HR plan was filled by current College staff with a resulting position vacancy also being filled internally. External recruitment resulted in the filling of one summer contract position and one additional permanent position. An in-person staff engagement event was hosted by the College in September and conference attendance was encouraged with two staff members attending CLEAR and one staff member attending CNAR.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2(D)-2	Human Resources Plan						
The College will have a Human Resources Plan that ensures the long-term sustainability and stability of the College.	• A Human Resources Plan that sets out the current and future plans for staffing of the College is developed and appended to the Operational Plan. • The Plan sets out the evolution of the staffing configuration that aligns with the Council's strategic plan and the College's Operational Plan.						
The Human Resources Plan will be updated annually and attached to the Operational Plan presented to the Council.	• Each year as the Operational Plan is updated, the Human Resources Plan is also updated to reflect any changing operations or operational priorities.						
Timeframe:	All 4 Planning Years				**Responsible:**	Senior Management Team	
Year-to-date outcomes:	In March 2024, an updated Human Resources Plan was presented to the Council as part of the Operational Plan. The plan set out a re-organization of the College and new positions to be developed and filled. The re-organization has been put into effect, positions descriptions created and recruitment undertaken.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Comments:	

2 (E)	Sound Financial Management.

2(E)-1	Effective financial management				
The financial resources of the College will be managed in accordance with generally accepted accounting principles and best practices for the not-for-profit sector and will meet all legislative and oversight requirements.				• Capital and Operating budgets will be developed for presentation to and acceptance by the Council, that will include a one-year budget and two years of estimates, based on a three-year operating plan. • Unaudited financial statements and the variance report will be provided to Council as part of the next Council meeting as soon as they are finalized and in accordance with the Councils Annual Planning Cycle (GP08). • The annual external audit of the College's financial status will be supported by the staff.	
Timeframe:	All 4 Planning Years			**Responsible:**	Director of Operations
Year-to-date outcomes:	As noted above, the Council was presented with the Auditor's Report and Audited Financial Statements for 2023-24 in July 2024. Subsequently, the unaudited financial statements at Q1 have been presented to and accepted by the Council. A draft budget for the next fiscal year will be presented in March 2025.				
Year-to-date rating:	❒ Not started	❒ In progress	❒ Completed	❒ To be deferred	
Comments:					

2 (F)	Transparency and Accountability

2(F)-1	Commitment to and Action on the Transparency principles
The College will operate a program that supports the transparency principles adopted by the Council and increases transparency of College decision-making wherever possible.	• A qualitative Annual Report that provides not only statistical information but also necessary context and trending information, will be developed and released annually.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

	• Audited financial statements and the Auditor's report will be presented to the Council at its July meeting and included in the Annual Report.
	• Regular Committee reports will be sought from Committee Chairs and included in the Council consent agenda for each Council meeting and Annual Committee reports will be developed by the staff and reviewed by Committee Chairs and presented to the Council in July.
	• Council and Executive Committee meeting materials will be made publicly available unless redacted in accordance with the Code. As such,
	  ○ Council meeting materials will be posted to the website prior to the Council meeting.
	  ○ Executive Committee materials will be posted to the website in advance of the meeting in accordance with the Committee terms of reference.

Timeframe:	All 4 Planning Years				**Responsible:**	Chief Executive Officer	
Year-to-date outcomes:	As noted above, the Council was presented with the Auditor's Report and Audited Financial Statements for 2023-24 in July 2024. At the same time, the Annual Committee reports were presented to the Council and both sets of documents have been posted to the College's website. Committee reports have been sought and presented to the Council at each of its three meetings thus far in 2024-25 and these too have been posted on the website. Similarly, the Report on Operations, Financial reports and Chair's Reports have also been made public via the website.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2(F)-2	Open Regulatory Process
• Regulatory processes and matters of the public interest will be routinely disclosed.	• The College will maintain (update regularly) a summary table of active and resolved complaints and inquiries on the website.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators
	• The College will alert the public to pending discipline hearings including the status of the matter and the notices of hearings. • Discipline hearing outcomes will be provided to the public, including posting on the website of Agreed Statements of Facts and Joint Submissions on Penalty and Costs, which are exhibits to hearings, and posting of Decisions and Reasons from panels of the Discipline Committee.

Timeframe:	All 4 Planning Years				**Responsible:**	Chief Executive Officer	
Year-to-date outcomes:	The summary of active and resolved complaints on the website have been updated. Updates to the hearings page have been regularly made, in particular with two on-going contested hearings during this period. No outcomes from the Discipline Committee have been made.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2(F)-3	Council Oversight Responsibilities		

The College will operate a reporting program to ensure that the Council is able to fulfill its oversight duties as set out in the Code, the Act and the College by-laws.			• The CEO will submit bi-monthly Regulatory Operations Reports to the Council detailing regulatory operational activities in line with part I of this Operational Plan. These reports will be made public.
			• The CEO will submit a semi-annual report on progress towards meeting the goals set out in this Operational Plan. As such,
			  ○ A mid-year report based on the work set out in the Operational (excluding Part 1) will be presented to the Council at its November meeting.
			  ○ A year-end report based on the work set out in the Operational Plan (including Part 1) will be presented to the Council at its July meeting.

Timeframe:	All 4 Planning Years	**Responsible:**	Chief Executive Officer

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Year-to-date outcomes:	Regulatory Operations Reports have been submitted to the Council at each of the three meetings thus far this year. The Operational year-end report for the prior year was presented to Council in July and this report is the mid-year report for the current planning year.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2(F)-4	CEO Annual Assessment		
The College will operate a program to ensure that the Council can properly assess the performance of the CEO.		• Staff will support the Council in its work to undertake a performance review of the CEO on an annual basis in accordance with its policies. • The Council will be provided with the necessary materials to undertake its review, which is based on the goals and development plan set by the CEO and approved by the Council.	
Timeframe:	All 4 Planning Years	**Responsible:**	Council

Year-to-date outcomes:	The Director of Operations has supported the Council's CEO Review Panel in its work. The review was conducted in schedule in the period April to July with the final reporting being presented to the Council at its July 2024 meeting.						
Year-to-date rating:	❒	Not started	❒	In progress	☑	Completed	❒ To be deferred
Comments:							

2(F)-5	Council Self-Assessment		
The College will operate a program to ensure that the Council can properly assess, its own performance, the performance of its committees and individuals Council and Committee members. #		• Staff will support the Council's Governance Evaluation process to enable the Council to undertake a performance review of itself, the Committees and individual Council and Committee members through an independent and neutral third party. # • Staff will oversee the support provided by a third-party consultant retained to assist the Council in its efforts. #	
Timeframe:	All 4 Planning Years	**Responsible:**	Chief Executive Officer

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Year-to-date outcomes:	The Council completed its annual assessment beginning in May 2024. The report was presented by Satori Consulting in July 2024.						
Year-to-date rating:	❒	Not started	❒	In progress	☑	Completed	❒	To be deferred
Comments:							

2(F)-6	Council Risk Assessment		
The College will operate a program that identifies and mitigates risks to the Council and the College.		• The CEO, on behalf of the Council, will maintain appropriate insurance policies to cover risks to the organization, including directors and officer's liability insurance, commercial general liability insurance and property insurance. These policies will be reviewed bi-annually. • The College will institute and manage an Enterprise Risk Management (ERM) Program and will support the Council's Risk Committee to ensure the Council is aware of the risks facing the College and processes instituted to mitigate those risks. • The ERM assessment will be updated annually.	
Timeframe:	All 4 Planning Years	**Responsible:**	Chief Executive Officer

Year-to-date outcomes:	At the time of this report seven out of eight risk registers have been completed. Document consolidation with associated risk mapping will be completed for Program roll out in Q4.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒	To be deferred
Comments:							

2 (G)	**Commitment to oversight requirements.**		
2(G)-1	HPARB Appeals		
The College will operate a program in support of the Health Professions Review and Appeal Board (HPARB) appeals process for appeals of decisions of the Registration Committee (RC) and for appeals of decisions of the Inquiries, Complaints and Reports Committee (ICRC).		• College staff will provide documentation relating to appeals to HPARB as soon as possible after receiving an alert of an appeal. • Legal Counsel for the College will be alerted and provided copies of all materials provided to HPARB.	

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

	• Staff will attend conferences and hearings in defence of RC decisions rendered and as a resource to HPARB in matters of appeals of ICRC decisions. • HPARB decisions will be reported to the Committees and the Council and any matters returned by HPARB will be brought to the appropriate committee on an expedited basis.

Timeframe:	All 4 Planning Years			**Responsible:**	Deputy CEO		
Year-to-date outcomes:	A total of 5 appeals related to College complaint outcomes have been filed. No hearings have been held during the first half of this planning year; however, one is scheduled for the latter half of the year and another scheduled for the 1st half of the 2025 planning year. No appeals were filed on registration decisions.						
Year-to-date rating:	❒	Not started	❒	In progress	❒	Completed	❒ To be deferred
Comments:							

2(G)-2	HRTO Matters
The College will operate a program that allows it to respond to matters filed with the Human Rights Tribunal of Ontario (HRTO).	• All notices received by the HRTO will be provided to Legal Counsel of the College. • College staff will support Legal Counsel by providing all necessary information to allow for a proper defence to be mounted. • College senior staff will participate in all conferences and hearings of the HRTO. • All outcomes of the HRTO will be reported to the Council and any impacted Committees.

Timeframe:	All 4 Planning Years	**Estimated cost:**		**Responsible:**	Chief Executive Officer		
Year-to-date outcomes:	One matter remains active with the HRTO; however, no communication has been received.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2(G)-3	College Performance Measure Framework

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

The College will support the work of the Ministry of Health in its oversight capacity through the **College Performance Measure Framework (CPMF)**.					• The College will assemble the necessary quantitate and qualitative data for the CPMF between January and March annually. • The College's draft submission will be presented to the Council in March annually. • Once approved, the report will be submitted to the Ministry. • The Ministry's summary of all College reports will be reviewed to identify best practices which this College may adopt in the future.		
Timeframe:	All 4 Planning Years				**Responsible:**	Senior Management Team	
Year-to-date outcomes:	The CPMF was presented to the Council in March 2024 and approved. The next report will be assembled at the end of the current calendar year and presented in March 2025.						
Year-to-date rating:	☑	Not started	❒	In progress	❒	Completed	❒ To be deferred
Comments:							

2(G)-4	Fair Registration Practices						
The College will support the work of the **Office of the Fairness Commissioner** (OFC) in its effort to ensure that registration practices of regulatory authorities are fair, objective, impartial and transparent.					• The College will submit the annual Fair Registration Practices report on the schedule set by the OFC and will make such reports publicly available. • The College will engage the OFC in support of its registration practices assessment conducted approximately every three years.		
The College is committed to registration practices that are transparent, objective impartial and fair, further incorporating recommendations made by the OFC in conjunction with their Risk-informed Compliance Framework, and best practices as highlighted by the Ontario Ministry of Health's CPMF Reporting.					• The College will seek to implement any additional recommendations resulting from further OFC assessments, changes to OFC fair registration practices or fair access requirements, or Ministry feedback in relation to the CPMF reporting.		
Timeframe:	All 4 Planning Years				**Responsible:**	Director, Registration and Examinations	
Year-to-date outcomes:	The College's Fair Registration Practices (FRP) report for the 2023 calendar year was submitted in May 2023 prior to the OFC's deadline. No additional assessment by the OFC of the College's registration practices outside of the						

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

	FRP report has been required. At the time of this report, the College's OFC assigned risk level remained "low risk."							
Year-to-date rating:	❒	Not started	❒	In progress	☑	Completed	❒	To be deferred
Comments:								

The following operational activities will be undertaken in support of the Council's second strategic objective and the five strategic priorities it has identified.

2.1	**Applicants are evaluated based on their competence and evaluations are relevant, fair, objective, impartial and free of bias and discrimination.**

2.1.1	Examinations
The College will operate an Examinations program that enables the College to properly assess the competencies of graduates from Council on Naturopathic Medical Education (CNME)-accredited programs and PLAR applicants seeking registration with the College, as well as naturopaths seeking to demonstrate that they have the competencies required of those standards.	• The College will deliver three (3) sittings of the Clinical (Practical) examinations annually. • The College will deliver two (2) sittings of the written Clinical Sciences examination annually. • The College will deliver two (2) sittings of the written Biomedical examination annually. • The College will deliver two (2) sittings of the Intravenous Infusion Therapy (IVIT) examination annually. • The College will deliver two (2) sittings of the Prescribing & Therapeutics examination annually. • The Ontario Jurisprudence exam will be available online.
All College examinations will be maintained through an examination question development and retirement program.	• A minimum of thirty (30) new examination questions will be developed annually in concert with item writers, item reviewers and the Examination Committee (ETP) for each of the BME and CSE • 25% of the questions and cases used in the Clinical (Practical) Exams will be reviewed annually.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

				• The College will support efforts by the Canadian Alliance of Naturopathic Regulatory Authorities in its effort to develop a national set of competencies and national examinations.	
Timeframe:	All 4 Planning Years	**Estimated cost:**	$319,283	**Responsible:**	Director, Registration and Examinations
Year-to-date outcomes:	At the time of this report, four examinations remain outstanding for this fiscal year (the December 2024 IVIT examination, the February 2025 Clinical (Practical) Exams, the February 2025 Clinical Sciences Exam and the March 2025 Biomedical Exam) with all other examinations having occurred as scheduled. The online jurisprudence examination remained available on demand, in English and French, without interruption. Question review and development activities were completed with new questions surpassing minimum numbers (see Regulatory Operations Report). The CANRA developed national entry to practise competency profile was accepted as Ontario's entry to practise competency profile by the Registration Committee in August 2024. Ongoing assistance (e.g., meeting attendance, provision of feedback, recruitment assistance etc.) continues in support of CANRA's efforts to develop a national entry to practise examination.				
Year-to-date rating:	❒ Not started	☑ In progress	❒ Completed	❒ To be deferred	
Comments:					

2.1.2	Entry-to-Practice
The College will operate an Entry-to-Practise program that enables new graduates, Prior Learning Assessment and Recognition (PLAR) applicants, and naturopaths registered in other jurisdictions to seek registration as a naturopath in the Province of Ontario.	• An application for registration process with the College will be maintained. • All applications will be screened to ensure that the entry-to-practise requirements set out in the Registration Regulation, College by-laws and Council policies are met. • Applicants that meet the requirements will be provided a Certificate of Registration. • Applicants that appear not to meet the requirements will be referred to the Registration Committee (RC) for review. Complete files for matters referred to the RC will be presented to the RC at

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators
	the first available meeting and staff will support the Committee by preparing Decisions & Reasons on files referred to the Committee for review and approval of the RC. Decisions & Reasons of the RC will be provided to applicants and registrants as soon as they are approved by the Committee. • Applicants referred to the Registration Committee will be kept informed of the progress of the review, both informally and formally through decisions rendered.
The College will operate a program that will allow an individual to be assessed to determine whether their education and experience is substantial equivalent under the Prior Learning Assessment and Recognition Program (PLAR) to that of an individual who has graduated from a CNME-accredited program.	• A process for evaluating individuals under the Council's PLAR policy will be maintained and applicants for assessment will be processed in accordance with that policy. • Current information about the PLAR process will be made publicly available by the College. • PLAR Assessors will be recruited and provided training and related tools to the assessment process. • Successful PLAR applicants will be invited to sit the Clinical (Practical) examinations and the Ontario Jurisprudence examination, and to make an application for registration under the Entry-to-Practise program.
The demonstration-based, components of PLAR ("Structured Interview" and "Interaction with a Simulated Patient") of the PLAR program will be reviewed and revised.	• Work will be carried out to phase out Stage 5 and enhance Stage 4 of PLAR: • A review will be conducted of Stage 5 demonstration-based competencies for necessity in determining substantial equivalency. • The Stage 4 assessment will be revised to include key Stage 5 competencies. • Associated staff and recruited demonstration-based assessors will be trained on the administration of the revised Stage 4 assessment process.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Timeframe:	All 4 Planning Years		**Responsible:**	Director, Registration and Examinations

Year-to-date outcomes:	See Regulatory Operations Report for info on ETP applications, referrals to the RC, and PLAR program applications. A PLAR assessor training was conducted in the first half of the year. Draft amendments to the PLAR program policy stemming from feedback from the PLAR Committee and a conducted PLAR working group were also completed in the first half of the year. Review of draft policy amendments and associated updates to the Program are anticipated in the second half of the year. Additional refinements to the revised demonstration-based portion of PLAR will likely extend into the first quarter of the 2025-26 fiscal year.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2.2	**Registrants and the public are aware of and adhere to the standards by which NDs are governed.**

2.2.1	Inspection Program
The College will operate an Inspection Program as set out in Part IV of the General Regulation made under the *Naturopathy Act, 2007,* to regulate premises in which IVIT procedures are performed.	• The College will maintain a process for new IVIT premises to become registered with the College and for registering of the designated registrant and other personnel operating from the premises and for existing premises to maintain their information with the College. • The College will maintain a process for the inspection of new premises as well as a process for the subsequent re-inspection of premises every five years. • Fees for new premises registered and inspections will be levied and collected. • A pool of qualified and trained inspectors will be maintained.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators
	• Incidences of IVIT procedures being provided in unregistered premises will be reviewed and, where appropriate, a request made to the Inquiries, Complaints and Reports Committee (ICRC) to appoint an investigator and a cease & desist letter is sent to the Registrant. • Inspection reports will be presented to the Inspection Committee, along with other relevant matters and staff will support the Committee by preparing materials for review, drafting decisions & Inspection Reports on files for review and approval of the Committee. Decisions of the Inspection Committee will be provided to the designated Registrant as soon as they are approved by the Committee. • The IVIT Premises Registry will be maintained on the College website with new and amending information added on a routine and regular basis. • Type 1 occurrence reports are reviewed by staff on receipt and reviewed by the Committee at the next meeting. If the Committee requires further action by the reporting Registrant, they will be contacted by staff. • Type 2 occurrence report forms will be collected annually, analyzed, and reported to the Committee and Council.

Timeframe:	All 4 Planning Years	**Estimated cost:**	$65,000		**Responsible:**	Deputy CEO	
Year-to-date outcomes:	See Regulatory Operations Report						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2.2.2	Standards Program
The College will operate a program to develop and maintain the Standards of Practise of the profession and any related policies and guidelines.	• College staff will support the SC as it initiates reviews of any or all of the Core Competencies, Code of Ethics and Standards and Guidelines.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators
Standards and guidelines will be reviewed by the Standards Committee (SC) to ensure that the standards fully support patient-centred care. New standards will be developed as identified by the Committee and/or Council.	• Staff will support the SC as it undertakes consultation of stakeholders relating to existing or new standards, guidelines or policies. • Where the SC makes amendments to any of the standards, guidelines or policies, staff will update the materials and release them publicly. • Staff will also maintain a program of alerting registrants of any changes to the standards.

Timeframe:	All 4 Planning Years				**Responsible:**	Deputy CEO	
Year-to-date outcomes:	The Standards Committee initiated a public consultation on amendments to 19 Standards of Practice. Review of the feedback will be undertaking in the second half of the planning year.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2.2.3	Regulatory Guidance Program
The College will operate a Regulatory Guidance program that will respond to registrants' questions and provide information, whenever possible, and guide the profession to the resources available to it.	• E-mail and telephone inquiries will be responded to by the Regulatory Education Specialist. • Statistics based on the number and nature (topic) of inquiries will be maintained and presented to the Council.

Timeframe:	All 4 Planning Years				**Responsible:**	Deputy CEO	
Year-to-date outcomes:	See Regulatory Operations Report						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2.3	**Registrants are held accountable for their decisions and actions.**

2.3.1	Registration of Individuals and Corporations
The College will operate a Registration program that enables naturopaths registered with the College to maintain their status with	• A registration renewal process will be conducted annually, in accordance with the by-laws that will enable all registrants to

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators
the College as individuals who hold either a General Class certificate of registration or an Inactive Class certificate of registration.	update their information with the College and pay their annual registration fees. • Class change applications will be processed by the College with those requiring a review by the RC being presented to the Committee with the information needed for decisions and with Decision & Reasons drafted based on Committee discussions, approved by the Committee, and provided to the Registrant. • The public registers will be maintained in accordance with the Code, regulations, and by-laws
The College will ensure that registrants maintain their CPR and PLI status as required under the by-laws.	• The College will monitor individual compliance with the requirements for a cardiopulmonary resuscitation certification and for carrying the necessary amounts of professional liability insurance. • Regular follow up with registrants whose CPR and/or PLI will expire will be undertaken. • Individuals who are not in compliance with these requirements will be provided notices and/or suspended in accordance with the Registration Regulation and the Code.
The College will operate a program that allows registrants to obtain Certificates of Authorization for professional corporations that they wish to establish.	• A process for registrants to apply for a Certificate of Authorization for a professional corporation will be maintained. • Applications will be reviewed, and decisions will be provided to registrants. • New corporations will be added to the Corporations register of the College. • A process for annual renewals of Certificates of Authorization will be maintained ensuring that all professional corporations are properly authorized.

Timeframe:	All 4 Planning Years	**Estimated cost:**	$21,000	**Responsible:**	Director, Registration and Examinations

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Year-to-date outcomes:	See Regulatory Operations report for info on class changes, and professional corporation Certificates of Authorization. 529 requests for updated public register photos were sent out in the first half of the year with 33 registrants receiving a Notice of Intent to Suspend for non-compliance. At the time of this report, preparation activities for the 2025-26 renewal period have been initiated, with renewal on track to launch on February 14, 2025. Regular monthly audits of PLI and CPR were conducted.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2.3.2	Patient Relations Program				
The College will operate a Patient Relations Program as set out in the *Regulated Health Professions Act, 1991*. Applications for funding will be accepted and reviewed under the new rules and patients entitled to funding supported by the College.				• A Patient relations program will be maintained. • Current information (handbooks) for registrants and patients will be maintained and made publicly available. • A process for applying for funding for counselling will be maintained in accordance with the Code. • Applications for funding will be presented to the Patient Relations Committee (PRC) at the next available meeting and decisions will be communicated to applicants.	
Timeframe:	All 4 Planning Years	**Estimated cost:**	$10,500	**Responsible:**	Deputy CEO
Year-to-date outcomes:	See Regulatory Operations Report				
Year-to-date rating:	❒	Not started	☑	In progress	❒ Completed ❒ To be deferred
Comments:					

2.3.3	Complaints & Reports

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

The College will operate a Complaints and Reports program to receive information and complaints about registrants of the profession and to fulfil its obligations to investigate the matters in accordance with the *Regulated Health Professions Act, 1991,* through the Inquiries, Complaints and Reports Committee (ICRC).						• Complaints received by the College will be processed in accordance with the Code. As such, • Concerns relating to professional misconduct or incompetence brought to the College's attention will be referred to the CEO for consideration of initiating a request for investigation. • Complaint and report files will be presented for the consideration and screening by the ICRC. • Complaints and Reports outcomes are monitored on an ongoing basis. Any deviation from ICRC decision is reported to the Deputy CEO. • The status and summary of active and closed complaints and reports are regularly updated and maintained on the College's website. • Program information will be maintained on the College's website.	
Timeframe:	All 4 Planning Years	**Estimated cost:**		**Responsible:**	Deputy CEO		
Year-to-date outcomes:	See Regulatory Operations Report						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2.3.4	Cease & Desist
The College will operate an Unauthorized Practitioners program that will issue Cease and Desist (C&D) letters to individuals not registered with the College who are holding themselves out as naturopathic doctors or providing naturopathic treatments and to registrants who are breaching the standards of practice in a manner that presents a risk of public harm.	• C&D letters are drafted and sent to the individual via Process Server, where applicable. • Names of unauthorized practitioners are posted on the Register of Unauthorized Practitioners on the College's website. • Staff follows up on the performance of signed confirmations and updates the Register of Unauthorized Practitioners. • Information regarding practitioners who have violated the confirmation is provided to the Deputy CEO. • Information about unauthorized practitioners who fail to sign a confirmation is provided to the Deputy CEO.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators
	• Matters are presented to the CEO for a decision on whether the College will seek an injunction from the Ontario Superior Court of Justice.

Timeframe:	All 4 Planning Years				**Responsible:**	Deputy CEO		
Year-to-date outcomes:	See Regulatory Operations Report							
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒	To be deferred
Comments:								

2.3.5	Alternative Dispute Resolution Program
The College will operate an Alternative Dispute Resolution (ADR) Program to ensure that matters that meet the eligibility criteria and are agreed to by both the Complainant and Registrant are properly resolved in accordance with section 25 of the RHPA and the program policies.	• Complaints received by the College will be reviewed by College staff for ADR eligibility. • An independent College approved Mediator is appointed for each eligible ADR matter. • A matter referred to ADR by the CEO must be completed and submitted for ratification within a maximum of 120 days of the referral.

Timeframe:	All 4 Planning Years				**Responsible:**	Deputy CEO		
Year-to-date outcomes:	See Regulatory Operations Report							
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒	To be deferred
Comments:								

2.3.6	Prosecution through Hearings
The College will operate a Hearings Program to ensure that matters that are referred by the Inquiries, Complaints and Reports Committee are properly adjudicated.	• Each matter referred by the ICRC will be assessed, and a determination made on the appropriateness of and opportunity for settlement. • Information for disclosure is provided to the CEO/legal counsel. • Matters that may be settled will proceed with a Pre-hearing conference as required, a draft Agreed Statement of Fact and

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators
	Joint Submission on penalty that is consistent with the outcomes of similar disciplinary matters of the College and other Colleges. • Where no settlement is possible or appropriate, a full contested hearing will be delivered with the CEO representing the College, with support of legal counsel, as prosecution. • The College will facilitate the Chair's selection of panels for hearings, coordinating hearings, counsel, Independent Legal Counsel (ILC) and witnesses and providing technological support for hearings of the Discipline Committee (DC) and Fitness to Practise Committee (FTP). • Discipline hearings are scheduled and held as required. • Information about current referrals to DC, hearings scheduled and completed, and DC decisions are published on the website and updated regularly. • The Registrant is notified of the ICRC decision and provided with a copy of allegations referred to DC. • Orders of panels will be monitored on an on-going basis to ensure the Registrant is in compliance. Any deviation from the order is reported to the CEO. • Terms, conditions and limitations imposed by the Panel and summaries of Undertakings are published in the Register.
As a corollary, the College will support the Discipline and Fitness to Practise Committees as quasi-judicial and independent adjudicative bodies.	• ILC will be retained by the College to provide on-going legal support to the Committee and the Chair. If requested by the Chair, a Request for Proposals will be developed and issued by the College with evaluations to be completed by the Committee. • Full committee meetings will be facilitated by the staff as directed by the Chair, including making necessary arrangements with ILC for training.

Timeframe:	All 4 Planning Years	**Estimated cost:**	$342,945	**Responsible:**	Chief Executive Officer

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Activity	Key Performance Indicators

Year-to-date outcomes:	In the first half of this program year, no new referrals have been made from the ICRC to the Discipline Committee. Two contested hearings started in the prior fiscal year have continued. A total of seven and one half days of hearings have been held between the two matters.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒	To be deferred
Comments:								

2.4	**Registrants maintain their competence as a means of assuring the public that they will receive safe, competent, ethical care.**

2.4.1	Quality Assurance Program

The College will operate a Quality Assurance (QA) Program as set out in the *Regulated Health Professions Act, 1991,* and the Quality Assurance Regulation made under the *Naturopathy Act, 2007*.	• Annual registrant self-assessment
	  ○ maintain and develop new online self-assessments to be annually completed by registrants.
	  ○ Review renewals to ensure all registrants have completed their annual self-assessment, follow up with those who do not.
	• Continuing Education (CE) Reporting, in three groups, one group each year
	  ○ The reporting group will be tracked, and CE reports analyzed.
	  ○ Follow up with those not received.
	  ○ Those not meeting requirements are presented to the Quality Assurance Committee (QAC) for review and further follow up.
	• Peer & Practise Assessment program
	  ○ QAC determines number of assessments to be completed and details of standards to be reviewed.
	  ○ Registrants are randomly selected and undergo assessment by a peer.
	  ○ Follow up with those who do not complete it or where issues are raised.

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

	○ A pool of qualified and trained assessors will be maintained. • CE course approval program ○ Applications for CE credits are presented to the QAC for review and approval. ○ List of approved courses is maintained on the website.

Timeframe:	All 4 Planning Years				**Responsible:**	Deputy CEO	
Year-to-date outcomes:	See Regulatory Operations Report						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2.4.2	Currency Hour Audits
The College's Registration program will establish and maintain a process for auditing the currency hours of registrants to ensure that they meet the requirements as set out in section 6 of the Registration Regulation or appropriate steps are taken to mitigate the potential risk to patients.	• Currency hour reporting cycles are tracked, and annually declared currency hours will be analyzed. • Notices will be sent to General Class registrants to alert them to their three-year currency cycle and accrued hours, starting in year one of their reporting cycle. • Annual currency hour audits will be conducted of those registrants who have completed their three-year currency cycle. • Those not meeting requirements will be provided with options as set out in the Registration Regulation and Registration policy for addressing currency hour deficiencies.

Timeframe:	All 4 Planning Years		**Responsible:**	Director, Registration and Examinations
Year-to-date outcomes:	75 registrants were issued an audit notice as a result of not meeting currency requirements as per the Registration Regulation and Registration Policy. 42 proposed refresher programs of training were reviewed by the Registration Committee in accordance with s. 6(2)(a) of the Registration Regulation and 19 referrals were made by the CEO to the Quality Assurance Committee for a Peer and Practice Assessment [s. 6(2) of the Registration Regulation].			

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

Year-to-date rating:	❒	Not started	❒	In progress	☑	Completed	❒	To be deferred
Comments:								

2.5	**The College examines the regulatory model to maximize the public protection benefit to Ontarians.**

2.5.1	Registration Regulation and Related Policies
In consultation with the Registration Committee, the College will undertake a comprehensive review of the structure and provisions of the Registration Regulation and related policies and make recommendations to the Council on any approaches that might maximize public protection for Ontarians. Wherever possible, recommendations that might reduce the overall reporting burden and "red tape" embodied in the regulation will be included.	• The College will consider the current classes of registration to determine if there is an alternative approach that might improve public protection and reduce the regulatory burden on registrants. This will include whether objectives achieved through TCLs set in policy would be better placed in Regulation. • The College will consider the current structure of the entry-to-practice examinations to determine whether there may be opportunities to streamline the examinations and improve timeliness of access to the profession. • The College will consider whether all of the current ETP requirements surrounding acupuncture and naturopathic manipulation should remain or whether an alternative post-certification approach, such as rostering, may be beneficial to public protection and access to the profession. • The College will consider whether a specialization program might be warranted and in the public interest. • The College will consider current requirements set out in by-laws and standards that might more appropriately be incorporated into the Registration Regulation to improve enforcement opportunities in the public interest. • The Registration Committee, with the support of and training from the EDIC, will apply the equity tool to the regulation and to make recommendations as to changes that may be warranted in

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

						keeping with the Council's commitment to equity, diversity, inclusion and belonging.	
Timeframe:	2024-2025				**Responsible:**	Chief Executive Officer	
Year-to-date outcomes:	The EDIC developed lens tool was utilized by the Registration Committee in it's review of new and existing policies. A comprehensive review of the Registration Regulation has not yet been initiated however ongoing consideration and discussions with respect to entry to practise examinations occurred in conjunction with work carried out to assist CANRA with development of its entry to practise competency profile and a national entry to practise practical examination.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

2.5.2	General Regulation and Related Policies						
In consultation with the Committees, the College will undertake a comprehensive review of the structure and provisions of the General Regulation and related policies and make recommendations to the Council on any approaches that might maximize public protection for Ontarians. Wherever possible, recommendations that might reduce the overall reporting burden and "red tape" embodied in the regulation will be included.					• The Committees and staff of the College, with the support of and training from the EDIC, will apply the equity tool to the regulation and to make recommendations as to changes that may be warranted in keeping with the Council's commitment to equity, diversity, inclusion and belonging.		
Timeframe:	All 4 Planning Years				**Responsible:**	Chief Executive Officer	
Year-to-date outcomes:	A preliminary review of the General Regulation has been conducted with some potential changes identified for consideration. An addition to the General Regulation has also been developed for consultation later this fall relating to naturopathic therapies as a way of strengthening and enhancing public safety.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

2.5.3	Professional Misconduct Regulation and Related Policies							
In consultation with the Inquiries, Complaints and Reports Committee, the College will undertake a comprehensive review of the structure and provisions of the Professional Misconduct Regulation and related policies and make recommendations to the Council on any approaches that might maximize public protection for Ontarians. Wherever possible, recommendations that might reduce the overall reporting burden and "red tape" embodied in the regulation will be included.							• The College will consider whether retaining the prohibition on the use of testimonials is in keeping with modern approaches to regulation or whether it might be restructured or removed. • The College will consider whether a program of specialization is recommended in other reviews and therefore whether changes to the Professional Misconduct Regulation might be warranted. • The College will consider whether a breach of by-laws should be included as a defined act of professional misconduct. • The ICRC and staff, with the support of and training from the EDIC, will apply the equity tool to the regulation and to make recommendations as to changes that may be warranted in keeping with the Council's commitment to equity, diversity, inclusion and belonging.	
Timeframe:	2024-2025				**Responsible:**	Chief Executive Officer		
Year-to-date outcomes:	A preliminary review has been undertaken as well as a review of the similar regulations for other professions to identify any gaps that may need to be addressed.							
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒	To be deferred
Comments:								

2.5.4	Quality Assurance Regulation and Related Policies
In consultation with the Quality Assurance Committee, the College will undertake a comprehensive review of the structure and provisions of the Quality Assurance Regulation and related policies and make recommendations to the Council on any approaches that might maximize public protection for Ontarians. Wherever possible, recommendations that might reduce the overall reporting burden and "red tape" embodied in the regulation will be included.	• The College will consider whether the structure of the Committee as mandated in the Regulation is appropriate and in the public interest. • The College will consider whether provisions mandating participating in a College developed program for Registrant portfolios is required or recommended. • The Quality Assurance Committee, with the support of and training from the EDIC, will apply the equity tool to the regulation and to make recommendations as to changes that may be

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All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

						warranted in keeping with the Council's commitment to equity, diversity, inclusion and belonging.		
Timeframe:	2025-2026					**Responsible:**	Chief Executive Officer	
Year-to-date outcomes:								
Year-to-date rating:	☑	Not started	❒	In progress	❒	Completed	❒	To be deferred
Comments:								

2.5.5	Standards Review							
In consultation with the Standards Committee, the College will undertake a comprehensive review of the structure and provisions of the standards and related policies and in the context of other recommendations made under this priority activity and will make recommendations to the Council on any changes necessary. Wherever possible, recommendations that might reduce the overall reporting burden and "red tape" embodied in the regulation will be included.						• The College will consider whether any commensurate amendments to the standards are necessary based on the proposed changes set out under the other area of this priority activity. • The Standards Committee, with the support of and training from the EDIC, will apply the equity tool to the standards and make recommendations as to changes that may be warranted in keeping with the Council's commitment to equity, diversity, inclusion and belonging.		
Timeframe:	All 4 Planning Years					**Responsible:**	Deputy CEO	
Year-to-date outcomes:	The Standards Committee has initiated a review of all standards. Proposed changes to the first set of 19 standards have been developed and a consultation process initiated.							
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒	To be deferred
Comments:								

2.5.6	By-laws Review
In consultation with the committee, the College will undertake a comprehensive review of the structure and provisions of by-laws in light of other recommendations made under this priority activity and will make recommendations to the Council on any changes that may be necessary. Wherever possible, recommendations that might	• The College will consider whether any commensurate amendments to the by-laws are necessary based on the proposed changes set out under the other area of this priority activity. • The staff of the College, with the support of and training from the EDIC, will apply the equity tool to the by-laws and make recommendations as to changes that may be warranted in

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

Activity	Key Performance Indicators

reduce the overall reporting burden and “red tape” embodied in the regulation will be included.			keeping with the Council’s commitment to equity, diversity, inclusion and belonging.				
Timeframe:	All 4 Planning Years			**Responsible:**	Chief Executive Officer		
Year-to-date outcomes:	By-law changes were last approved by the Council in May 2024; however, a process of on-going review is in place as the College fulfills its mandate and changes to regulations are contemplated.						
Year-to-date rating:	❒	Not started	☑	In progress	❒	Completed	❒ To be deferred
Comments:							

Index:

All 4 Planning Years	2023-2024	2024-2025	2025-2026	2026-2027

The College of Naturopaths of Ontario

MEMORANDUM

DATE:	November 18, 2024
TO:	Council members College of Naturopaths of Ontario
FROM:	Agnes Kupny Director, Operations
RE:	Variance Report – Q2 Unaudited Financial Statements

I am pleased to provide the Variance Report and Unaudited Financial Statements of the College of Naturopaths of Ontario (the College) as of the second quarter (Q2) of our 2024-2025 fiscal year.

Statement of Financial Position

The Statement of Financial Position provides a snapshot of the financial standing of the organization at the point in time for which it is dated, in this case, as of September 30, 2024.

At the end of Q2 monies from the College's Operating Funds were transferred into its Savings account, which is interest bearing. The College's Operating Funds account, which acts as our chequing account, is utilized regularly to both accept the deposit of monthly payments of registration fees, any program fees paid by credit card including exams and inspections, and to pay all of our monthly expenses including rent.

Accounts Receivable had a balance of $627,686.88 the majority of which is attributable to payments made by registrants (through preauthorized debiting of their bank account) to the College's payment plan, which allows registrants to pay their 2024-25 registration fee in ten installments between April 2024 and January 2025 rather than in one lump sum. As of the end of September, six of the ten payment plan deductions had occurred.

The balance for DC ordered costs decreased by $13,600 as a result of one registrant paying their ordered costs in full. The remaining balance of $85,128 continues to represent costs ordered by the Discipline Committee which remain unpaid.

Under Other Current Assets, Prepaid Expenses decreased by $27,796.18 as a result of the return of the College's security deposit for our previous (John St.) office location. The balance of $70,729.74 is made up of the following: the security deposit for our current (King St.) office location, College membership fees including CANRA, insurance, exam maintenance contracts and software subscriptions.

Fixed Assets, which is the value of all physical assets the College owns after the equipment has depreciated over a three-year period, was noted at $51,607.60, constituting a slight increase of approximately $3,000 due to the recent capital purchase of a laptop.

Under Liabilities and Equity, the Accounts Payable account had a balance of $122,172.08 which represents payments that had not yet cleared at the end of the quarter for legal, investigations and exam costs.

Accrued Liabilities, under Other Current Liabilities, decreased by $29,067.11 as a result of some employees using up their vacation accruals over the summer months. The remaining balance of $6,514.49 is unused vacation accruals that must be used by staff before the end of Q4.

Deferred Income in the amount of $25,070 represents collected fees for examinations, inspections and ordered peer and practice assessments that have not yet occurred.

HST Payable under Other Current Liabilities, in the amount of $63, 667.62 is monies owing that have been remitted for six of the ten months in which the pre-authorized payment plan has been in place. This balance is determined by the total in Accounts Receivable and decreases month over month as the balance of the Accounts Receivable decreases.

Under Equity, all of the established Reserve Funds and Retained Earnings are adjusted at the completion of our annual audit, once per fiscal year.

Statement of Operations

The Statement of Operations, as well as an analysis of the Statement of Operations, are attached following the Statement of Financial position. For the analysis, the coloured legend is as follows:

- Blue- notes actual budget, actual expenditures and variances for Q2 only.
- Orange- notes actual budget, actual expenditures and variances for Q2 only from the previous year.
- Green- comparison of current actual year vs. previous actual year to illustrate variances.
- Pink- notes the actual annual budget, year-to-date revenue/expenses and the percentage of the budget received or spent to date.

Revenue

Total Year-to-Date revenue was $3,613,680. At the end of the second quarter the College is 11% away from meeting its annual budgeted revenue target of $4,039,300.

Revenue items that are either under or over 10% materiality against the Q2 budget are noted below.

	Current 2024-2025 Fiscal Year				Deviation Comparisons	
Line Item	**Actual Revenue at Q2**	**Budget at Q2**	**Q2 actual vs Budget at Q2 in $**	**% Q2 actual vs Budget at Q2**	**Q2 actual vs. Q2 actual prior fiscal year in $**	**Q2 actual vs. Q2 actual prior fiscal year in %**
Registration Fees	$10,430	$19,435	($9,005)	54%	$1,652	19%
Incorporation Fees	$9,213	$8,040	$1,173	115%	$2,013	28%
Interest	$3,246	$5,400	($2,154)	60%	($4,796)	(60%)

Investment Income	$19,057	$15,000	$4,057	127%	$1,861	11%
Miscellaneous Income	$45	$0	$45	100%	$45	100%

Registration Fees (99% of YTD Budget)– Q2 saw a $9,005 shortfall attributed to lower than anticipated initial registration numbers for entry to practise, with the program receiving four applications for registration vs the budgeted 20 and issuing five certificates for registration as opposed to the budgeted 10.

Incorporation Fees (46% of YTD Budget)– Incorporation fees exceeded the Q2 budget by 15% with a total of three corporation application fees received and four certificates of authorization issued.

Interest (20% of YTD Budget)- While the College has two bank accounts, only the Savings account is interest generating. At the end of Q2, interest earned is lower than budgeted due to the account balance being lower in July in the Savings account while monies were being transferred from the Operating Funds account to the Savings account.

Investment Income- (63% of YTD Budget)- The College's investment portfolio includes a GIC and Mutual funds. While the Bank of Canada interest rates were anticipated to come down in September 2024, as factored into budgeted projections, this did not occur. As a result, the revenues are higher than budgeted for this period.

Miscellaneous Income- (23% of YTD Budget)- The College has a small allocation every year for miscellaneous revenue. This quarter, the noted $45 was staff purchase of office equipment that was no longer being used by the College.

Expenses

Total Year-to-Date expenses were $1,720,116 representing a 43% utilization of the annual budget of $4,020,781.

This quarter all expense line items that did not meet Q2 budgeted targets, and line items that are either under or over 10% materiality, are noted below.

	Current 2024-2025 Fiscal Year				Deviation Comparisons	
Line Item	**Actual Expenses at Q2**	**Actual Budget at Q2**	**Q2 actual vs Budget at Q2 in $**	**% Q2 actual vs Budget at Q2**	**Q2 actual vs. Q2 actual prior fiscal year in $**	**Q2 actual vs. Q2 actual prior fiscal year in %**
Rent and Utilities	$41,758	$49,065	$7,307	15%	($5,407)	(11%)
Office and General	$34,418	$54,483	$20,064	37%	$2,315	7%
Consulting Fees- General	$7,863	$12,500	$4,637	37%	($335)	(4%)

Consulting Fees- Complaints and Inquiries	$37,388	$34,250	($3,138)	(9%)	$18,404	97%
Consulting Fees- Assessors/ Inspectors	$6,514	$23,700	$17,186	73%	($581)	(8%)
Exam Fees	$78,873	$96,935	$18,062	19%	$13,710	21%
Legal Fees- General	$17,925	$5,395	($12,530)	(232%)	$13,447	300%
Legal Fees- Complaints	$3,611	$13,300	$9,690	73%	($3,610)	(50%)
Legal Fees- Discipline	$132,554	$0	($132,554)	(100%)	$81,556	160%
Council Fees and Expenses	$13,862	$40,398	$26,535	66%	($43,442)	(76%)
Hearings	$7,466	$0	($7,466)	(100%)	$1,012	16%
Insurance	$25,244	$35,000	$9,756	28%	$2,205	10%
Equipment Maintenance	$8,863	$14,340	$5,477	38%	($5,714)	(39%)
Public Education	$17,612	$22,710	$5,098	22%	$9,269	111%
Education and Training	$1,409	$0	($1,409)	(100%)	($1,806)	(56%)
Postage and Courier	$200	$359	$159	44%	$30	18%

Rent and Utilities (47% of YTD Budget)- In addition to the return of the College's security deposit the College was also in receipt of a credit for the adjustment of property taxes and utilities from our previous landlord at John St.

Office and General (28% of YTD Budget)- This line item is typically comprised of various office expenses including office supplies, janitorial costs, costs associated with staff recognition events, translation costs, credit card fees and photocopying costs. At Q2 the College incurred minimal photocopying costs, no janitorial costs, no recruitment costs and no translation costs. This year, a total of five staff are celebrating work anniversaries with one event to celebrate these work milestones scheduled for Q3.

Consulting Fees- General (28% of YTD Budget)- This line item represents consulting fees for all program areas except ICRC investigators and Inspectors/Assessors under the Professional Practice program. The cost savings experienced in this area in Q2 were due to fewer database enhancements being performed than budgeted, the Quality Assurance programming project being delayed to Q3-Q4, and the budgeted contract consultant, for initiation of the Enterprise Risk Management Program, being replaced with a Manager, Risk and Finance position as per the new HR plan.

Consulting Fees- Inquiries and Complaints (42% of YTD Budget)- This line represents the costs of external investigators retained by the College on behalf of the ICRC. In Q2, the College

received five new complaints, closed six complaints, initiated one Registrar's (CEO) report investigation and closed one Registrar's (CEO) report investigation.

Consulting Fees- Assessors and Inspectors (14% of YTD Budget)- In Q2, 47 peer and practice assessments were completed, representing a 30% increase over the amount budgeted. Additionally, four new premises, six part-one inspections for new premises and three 5-year inspections were conducted. No part-two inspections were completed. As a result of the lack of part-two inspections and the majority of peer and practise assessments having taken place in September, for which assessor expense claims were still pending at end of Q2, consulting fees were lower than budgeted.

Legal Fees-General (91% of YTD Budget)- This account covers costs associated with legal advice for all College activities except complaints and discipline, which are accounted for separately. This quarter the College had higher than normal legal fees in operations due to an unanticipated lawsuit, for which had not been budgeted.

Legal Fees- Complaints (8% of YTD Budget)- This quarter the College opened five new complaints, closed six complaints, initiated one Registrar's (CEO) report investigation and closed one Registrar's (CEO) report investigation. This quarter the number of complaints and reports on which legal advice was required was lower than anticipated.

Legal Fees-Discipline (175% of YTD Budget)- This account represents legal costs for discipline matters, including prosecution costs and the costs associated with independent legal counsel. This quarter a total of six full days of hearings took place for two separate matters. The scheduling of actual hearings varied from the budget thus affecting legal costs.

Hearings (81% of YTD Budget)- This account reflects all costs associated with hearings of the Discipline Committee except legal costs. This includes Panel per diems, fees for a court reporter and translation costs. As noted above, the actual hearing schedule varied from that anticipated in the budget.

Equipment Maintenance (39% of YTD Budget) – In Q2 the College was in receipt of a vendor credit for a full month of IT services for some unanticipated project delays by the vendor.

Public Education (28% of YTD Budget) – This quarter some cost savings were realized for this program area as the College has begun to facilitate the role of the moderator in REP and ICW webinars internally vs. using an external vendor. The level of IT assistance that staff have required in supporting the website also decreased as a result of increased staff familiarity with the new platform. Expense-wise, a partial payment for the first phase of the design process of the Annual Report was made.

Education and Training (21% of YTD Budget) – Every year the College budgets for staff professional development, with the majority of the budget allocated to Q1 when performance appraisals are completed. However, the timing of when staff undertakes approved professional development activities varies throughout the fiscal year. In Q2, there were two staff enrollments in professional development courses/activities.

Postage and Courier (15% of YTD Budget) – The postage machine is being replenished on an as needed basis, with the majority of College communications being sent electronically. This quarter the postage machine was replenished in the amount of $200, which is 56% of the budget allocated for Q2.

Capital Expenditures

The College's IT budget is being used to replace end-of-life equipment and purchase new equipment in accordance with the Human Resources plan. As previously noted, one laptop was purchased in Q2.

This report is a highlight of the overall financial picture of the College for the relevant reporting period. If you have any questions or would like to discuss any aspects of this report, I am happy to do so.

Respectfully submitted.

The College of Naturopaths of Ontario

STATEMENT OF FINANCIAL POSITION

As of September 30, 2024 (Q2)

50% of Fiscal Year

ASSETS			
Chequing / Savings			
Bank - Operating Funds	$	161,182.59	
Bank - Savings	$	1,456,294.57	
Petty Cash	$	500.00	
Total Chequing / Savings			*$ 1,617,977.16*
Accounts Receivable			
Accounts Receivable	$	627,686.88	
Allowance for Doubtful Accounts	$	(48,361.66)	
Ordered DC Costs	$	85,128.04	
Total Accounts Receivable			*$ 664,453.26*
Other Current Assets			
Prepaid Expenses	$	70,729.74	
Investment in Mutual funds	$	1,706,832.78	
Accrued Interest	$	14,687.06	
Investment in GIC	$	(25,985.53)	
Total Other Current Assets			*$ 1,766,264.05*
Fixed Assets			
Construction	$	-	
Computer Equipment	$	104,764.14	
Furniture and Fixtures	$	157,256.73	
Accumulated Amortn - Computers	$	(133,328.33)	
Accumulated Amortn - Furniture	$	(77,084.94)	
Total Fixed Assets			*$ 51,607.60*
TOTAL ASSETS			**$ 4,100,302.07**
LIABILITIES AND EQUITY			
Accounts Payable			
Accounts Payable	$	122,172.08	
Credit cards	$	-	
Total Account Payable			*$ 122,172.08*
Other Current Liabilities			
Accrued Liabilities	$	6,514.49	
Accrued Liabilities-Discipline	$	-	
Deferred Income	$	25,070.00	
HST Payable	$	63,667.62	
Total Current Liabilities			*$ 95,252.11*
Equity			
Retained Earnings	$	(254,459.97)	
Patient Relations Fund	$	90,385.13	
Business Continuity Fund	$	1,093,584.00	
Investigations and Hearning Fund	$	1,009,100.00	
Succession Planning Fund	$	50,000.00	
Current Earnings	$	1,894,268.72	
Total Equity			*$ 3,882,877.88*
TOTAL LIABILITIES AND EQUITY			**$ 4,100,302.07**

The College of Naturopaths of Ontario

Analysis of the Q2 Statement of Operations Compared to the Previous Year
July 01, 2024 to September 30, 2024

	Q2													
	JUL-SEP'24 BUDGET $'s	JUL-SEP'24 ACTUAL $'s	BUDGET FAV (UNFAV) VARIANCE		JUL-SEP'23 BUDGET $'s	JUL-SEP'23 ACTUAL $'s	BUDGET FAV (UNFAV) VARIANCE		VARIANCE FROM PREVIOUS YEAR	VARIANCE FROM PREVIOUS YEAR	ANNUAL BUDGET	YTD Actual	% OF BUDGET REC'D AND/OR SPENT
Revenue			$	%			$	%	$	%	$	$	%
Registration Fees	19,435	10,430	(9,005)	54%	18,078	8,778	(9,300)	49%	1,652	19%	3,351,649	3,315,265	99%
Examination Fees	152,290	167,780	15,490	110%	181,150	82,125	(99,025)	45%	85,655	104%	298,535	205,000	69%
Assessment Fees	-	-	-	0%	0	0	-	0%	-	100%	1,000	-	0%
Incorporation Fees	8,040	9,213	1,173	115%	6,450	7,200	750	112%	2,013	28%	44,316	20,502	46%
Ordered Costs Recovered	-	-	-	-	0	3,138	3,138	-	(3,138)	-100%	180,000	-	0%
Inspection Fees	20,500	18,600	(1,900)	91%	42,500	25,300	(17,200)	60%	(6,700)	-26%	82,000	30,700	37%
Interest	5,400	3,246	(2,154)	60%	600	8,042	7,442	1340%	(4,796)	-60%	21,600	4,385	20%
Investment Income	15,000	19,057	4,057	127%	3,500	17,196	13,696	491%	1,861	11%	60,000	37,783	63%
Miscellaneous Income	-	45	45	100%	100	-	(100)	0%	45	100%	200	45	23%
Total Revenue	220,665	228,372	7,707	103%	252,378	151,779	(100,599)	60%	76,593	50%	4,039,300	3,613,680	89%
Expenses													
Salaries and Benefits	589,528	550,207	39,321	7%	509,192	495,472	13,720	3%	54,735	11%	2,437,970	988,770	41%
Rent and Utilities	49,065	41,758	7,307	15%	51,600	47,165	4,435	9%	(5,407)	-11%	196,260	92,913	47%
Office and General	54,483	34,418	20,064	37%	77,681	32,103	45,578	59%	2,315	7%	271,635	74,765	28%
Consulting Fees-General	12,500	7,863	4,637	37%	4,000	8,198	(4,198)	-105%	(335)	-4%	47,800	13,528	28%
Consulting Fees-Complaints and Inquires	34,250	37,388	(3,138)	-9%	32,250	18,984	13,266	41%	18,404	97%	134,000	55,649	42%
Consulting Fees-Assessors/Inspectors	23,700	6,514	17,186	73%	15,000	7,095	7,905	53%	(581)	-8%	72,300	10,308	14%
Exam Fees and Expenses	96,935	78,873	18,062	19%	106,547	65,163	41,384	39%	13,710	21%	261,578	148,417	57%
Legal Fees-General	5,395	17,925	(12,530)	-232%	6,800	4,478	2,322	34%	13,447	300%	23,450	21,267	91%
Legal Fees-Complaints	13,300	3,611	9,690	73%	13,000	7,220	5,780	44%	(3,610)	-50%	105,350	8,734	8%
Legal Fees-Discipline	-	132,554	(132,554)	-100%	15,000	50,998	(35,998)	-240%	81,556	160%	95,000	166,319	175%
Council Fees and Expenses	40,398	13,862	26,535	66%	102,595	57,304	45,291	44%	(43,442)	-76%	113,818	37,304	33%
Hearings (Discipline, Fitness to Practice)	-	7,466	(7,466)	-100%	-	6,454	-	-	1,012	16%	19,595	15,828	81%
Amortization/Depreciation	-	-	-	0%	-	-	-	0%	-	0%	11,759	-	0%
Insurance	35,000	25,244	9,756	28%	-	23,039	-	-	2,205	10%	39,500	32,924	83%
Equipment Maintenace	14,340	8,863	5,477	38%	12,690	14,577	(1,887)	-15%	(5,714)	-39%	56,760	21,902	39%
Audit Fees	-	-	-	0%	17,000	16,400	600	0%	(16,400)	0%	19,000	-	0%
Public Education	22,710	17,612	5,098	22%	11,420	8,343	3,077	27%	9,269	111%	106,265	29,719	28%
Education and Training	-	1,409	(1,409)	-100%	2,225	3,215	(990)	-44%	(1,806)	-56%	7,300	1,559	21%
Postage and Courier	359	200	159	44%	328	170	158	48%	30	18%	1,442	210	15%
Total Expenses	991,962	985,766	6,196	1%	977,328	866,376	110,952	11%	119,390	14%	4,020,781	1,720,116	43%
Total Revenue over Expenses	(771,297)	(757,394)	1,511	0%	(724,950)	(714,597)	(211,551)	29%	(42,797)	6%	18,519	1,893,564	

The College of Naturopaths of Ontario

Statement of Operations

	2024-2025			
	Budget	Y-T-D Actual	YTD as % of Budget	Apr-Sept'24 Budget
REVENUES				
Registration and member renewal fees	$ 3,351,649	$ 3,315,265	99%	$ 3,254,347
Examination fees	$ 298,535	$ 205,000	69%	$ 194,965
Assessment fees	$ 1,000	$ -	0%	$ 500
Incorporation fees	$ 44,316	$ 20,502	46%	$ 19,902
Ordered costs recovered	$ 180,000	$ -	0%	$ 165,000
Inspection fees	$ 82,000	$ 30,700	37%	$ 41,000
Interest	$ 21,600	$ 4,385	20%	$ 25,900
Investment Income	$ 60,000	$ 37,783	63%	$ 30,000
Miscellaneous	$ 200	$ 45	23%	$ 100
TOTAL REVENUES	$ 4,039,300	$ 3,613,680		$ 3,731,714
EXPENSES				
Salaries and benefits	$ 2,437,970	$ 988,770	41%	$ 1,202,393
Rent and utilities	$ 196,260	$ 92,913	47%	$ 98,130
Office and general	$ 271,635	$ 74,765	28%	$ 150,841
Consulting fees				
Consultants - general	$ 47,800	$ 13,528	28%	$ 19,700
Consultants - complaints and inquiries	$ 134,000	$ 55,649	42%	$ 69,500
Consultants - assessors/inspectors	$ 72,300	$ 10,308	14%	$ 38,400
Exam fees and expenses	$ 261,578	$ 148,417	57%	$ 160,016
Legal fees				
Legal fees - general	$ 23,450	$ 21,267	91%	$ 10,713
Legal fees - complaints	$ 105,350	$ 8,734	8%	$ 37,675
Legal fees - discipline	$ 95,000	$ 166,319	175%	$ 65,000
Council fees and expenses	$ 113,818	$ 37,304	33%	$ 63,685
Hearings (Discipline, Fitness to Practise)	$ 19,595	$ 15,828	81%	$ 15,610
Amortization/Depreciation	$ 11,759	$ -	0%	$ -
Insurance	$ 39,500	$ 32,924	83%	$ 39,500
Equipment maintenance	$ 56,760	$ 21,902	39%	$ 28,480
Audit fees	$ 19,000	$ -	0%	$ -
Public education	$ 106,265	$ 29,719	28%	$ 80,645
Education and training	$ 7,300	$ 1,559	21%	$ 6,000
Postage & Courier	$ 1,442	$ 210	15%	$ 723
TOTAL EXPENSES	$ 4,020,781	$ 1,720,116		$ 2,087,010
EXCESS OF REVENUES OVER EXPENSES	$ 18,519	$ 1,893,564		$ 1,644,704

The College of Naturopaths of Ontario

2024-25 Capital Statement

Line Item	Total Budget (April 2024-March 2025)	April	May	June	July	August	September	October	November	December	January	Febuary	March	YTD Actual	Balance
Computer Equipment	$10,000.00					$3,518.39								$3,518.39	$6,481.61
Furniture & Fixtures	$6,000.00													$0.00	$6,000.00
Leasehold Improvement	$0.00													$0.00	$0.00
Total	$16,000.00													$3,518.39	$12,481.61

The College of Naturopaths of Ontario	Policy Type GOVERNANCE PROCESS	COUNCIL POLICIES
	Title Committee Principles	Policy No. GP06.0~~98~~
		Page No. 1

Committees established under the Regulated Health Professions Act, 1991 shall perform the function that is assigned to them under the authority of the Act. Committees established by the Council will be assigned to reinforce the wholeness of the Council's job and never interfere with the delegation from the Council to the CEO.

Definitions	Statutory Committee	Means a group of individuals appointed by the Council of the College of Naturopaths of Ontario in accordance with the *Regulated Health Professions Act, 1991*.
	Standing Committee of Council	Means a group of individuals appointed by the Council of the College of Naturopaths of Ontario under this policy with an on-going function determined by the Council and that makes recommendations to the Council. Such committees are non-statutory committees.
	Ad hoc Committee or Working Group	Means a group of individuals appointed by the Council of the College of Naturopaths of Ontario under this policy with a specified and time limited task or function on which they shall report and make recommendations to the Council. Such committees may be referred to by any number of names, including but not limited to an ad hoc committee, working group or task force. Such committees are non-statutory committees.
	Operational Committee	Means a group of individuals appointed by the CEO to perform management or operational functions or to provide advice to the CEO.

Accordingly,

1 Statutory Committees (SC)

(a) Shall be appointed by the Council in accordance with the *Regulated Health Professions Act, 1991* (RHPA) and the *Naturopathy Act, 2007* (the Act) and its regulations and by-laws, and shall perform the functions assigned to it by the RHPA and as further clarified in Terms of Reference approved by Council.

(b) Shall establish panels, as appointed by the Chair of the Committee, and must conform to the requirements of the *Regulated Health Professions Act, 1991* and the *Naturopathy Act, 2007,* the regulations and by-laws.

(c) In as much as the Committee panels are acting as tribunals, they are responsible for the content of their decisions, which may be reviewed only by the Health Professions Appeal and Review Board or a Court of Law.

(d) May direct the CEO to take action or implement its decisions in accordance with the individual legislative authority of the Statutory Committee.

(e) The following committees are designated as Statutory Committees of the Council of the College of Naturopaths of Ontario.

i. Discipline Committee (SC01).
ii. Executive Committee (SC02).
iii. Fitness to Practise Committee (SC03).
iv. Inquiries, Complaints and Reports Committee (SC04).
v. Quality Assurance Committee (SC05).
vi. Patient Relations Committee (SC06).

DATE APPROVED	DATE LAST REVISED
July 30, 2013	March 30, 2022

vii. Registration Committee (SC07).

2 Standing Committees of Council (CC) and Ad Hoc Committees (AHC)

(a) Will assist the Council by preparing policy alternatives and implications for Council deliberation; however, in keeping with the Council's broader focus, Council committees will not have dealings with operations.

(b) May not speak or act for the Council except when formally given such authority for specific and time limited purposes.

(c) Will have written terms of reference wherein the expectations and authority of the Committee will be carefully stated in order not to conflict with authority delegated to the CEO or another Committee.

(d) Cannot exercise authority over staff. Because the CEO works for the full Council, they will not be required to obtain approval of a Council Committee before taking an executive action.

(e) Chairs of Council Committees may work directly with the staff when so authorized by the CEO.

(f) The following committees are designated as Standing Committees of Council.

i. Audit Committee (CC01).
ii. Scheduled Substances Review Committee (CC02).
iii. Examinations Appeals Committee (CC03).
iv. Governance Committee (CC04).
v. Inspection Committee (CC05).
vi. Governance Policy Review Committee (CC06).
vii. Standards Committee (CC07).
viii. Equity, Diversity and Inclusion Committee (CC08).
ix. Risk Committee (CC09).

(g) The following is designated as an Ad Hoc Committee of the Council:

~~ix.~~ i. Working Group on the Identification and Mitigation of Patient Harm (AHC01).

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3 Operational Committees shall be appointed at the discretion of the CEO. Terms of Reference for all Operational Committees shall be developed for each Committee and are subject to acceptance by the Council.

4 This policy applies to any group that is formed by Council action, whether or not it is called a Committee and regardless of whether the group includes Council members. It does not apply to committees formed under the authority of the CEO.

5 With the exception of the Executive Committee as set out in that Committee's Terms of Reference, all committee meetings and related materials are closed to the public in order to allow the committees to properly execute their statutory and Council appointed duties.

6 To reflect the duality of the College as a joint endeavor of dedicated volunteers and staff, all committee meetings shall have at least one staff person appointed

by the CEO in attendance. Committees shall not exclude staff from all or part of the meeting (including in camera meetings), unless one of the following conditions are met and the CEO is advised in advance of the meeting:

a) Personnel matters that are within the duties and responsibilities of that committee will be discussed;
b) Instructions will be given to or opinions received from legal counsel of the College that involve or relate to personnel of the College.

7 Should individual committee members have concerns about staff performance with respect to the committee's work, they will raise those directly with the Committee Chair who shall in turn raise those with one or both of the Council Chair and Chief Executive Officer.

Section	Committee	Page
Governance Process	WGIMPH (AHC01.00)	1
		Create Date: May 13, 2024

Authority and Accountability	The Working Group on the Identification and Mitigation of Patient Harm (WGIMPH) is a working group that is sponsored and supported by the Council of the College of Naturopaths of Ontario and is established pursuant to section GP06 - Committee Principles.
Limitations	The WGIMPH shall only exercise the authority and fulfill the duties and responsibilities authorized in these Terms of Reference and has no direct authority over the governance or operations of any of its members.
Responsibilities	The WGIMPH will work collaboratively to identify and mitigate risks of harm to Ontario Naturopathic patients by: • Receiving and analyzing data from the Risk-based Regulation Program of the College of Naturopaths of Ontario; • Identifying current and potential future risks of harm to Ontario naturopathic patients based on trends identified in the data; • Recommend programs to mitigate those risks of harm to patients, collectively and in collaboration with individual member organizations. • Report on identified risk trends to the member organizations, to patients and to Ontario's Naturopathic Doctors; • Monitor the success of the Risk-based Regulation Program of the College and recommend methods to ensure total quality improvement of the validity and reliability of the data.
Appointment and composition	The WGIMPH shall be comprised of up to two representatives appointed by each of the following organizations: • College of Naturopaths of Ontario; • Ontario Association of Naturopathic Doctors; • Canadian College of Naturopathic Medicine (Toronto campus); • Ontario Ministry of Health. The WGIMPH shall annually elect a Chair from among its members.
Term of Office	The WGIMPH members shall be appointed by the member organizations and shall remain until such time as they are removed or replaced by the individual organization.
Meetings	The WGIMPH shall meet at least four times per year by video conference on a date and at a time set by the WGIMPH Chair at least ten days in advance of the meeting date unless a majority of Committee members agree to a shorter period. If the Chair is unable to preside at a duly called meeting, the Chair may designate an acting Chair from among the WGIMPH members, or where the Chair has not done so, an acting Chair for the meeting shall be selected by and from among the WGIMPH members present.

DATE APPROVED	DATE OF UPDATE	RESPONSIBLE
		Council

Section	Committee	Page
Governance Process	WGIMPH (AHC01.00)	2
		Create Date: May 13, 2024

Quorum	Quorum for meetings of the WGIMPH shall be two individuals representing a minimum of two different member organizations.
Reports	The Chair, on behalf of the WGIMPH, shall provide a Report on the WGIMPH activities to the Chief Executive Officer of each member organization within 30 days of the end of each WGIMPH meeting. an Annual Report on the performance of its responsibilities and outcomes
Support	Administrative support to the WGIMPH would be provided by the College of Naturopaths of Ontario which would: • Arrange and deliver meetings, including the use of the College's video conferencing platform, • Assemble and disseminate data and other meeting materials, • Take minutes of meetings, • Support the Chair in development and dissemination of any Reports.
Per diem, expenses and other costs	Each member organization is responsible for paying for any per diem or expenses for their individual representatives, to the degree that they are required.

The College of Naturopaths of Ontario

BRIEFING NOTE
Educational Briefing – Inspections

BACKGROUND

The College of Naturopaths of Ontario is established under the *Naturopathy Act, 2007* and the *Regulated Health Professions Act, 1991*. Its duty, as set out in the legislation, is to serve and protect the public interest. Its mandate is to support patients' rights to receive safe, competent, and ethical naturopathic care.

The College achieves its mandate by performing four key functions.

1. **Registering Safe, Competent, and Ethical Individuals -** The College establishes requirements to enter the practise of the profession, sets and maintains examinations to test individuals against these requirements, and register competent, ethical and qualified individuals to practise naturopathy in Ontario.

2. **Setting Standards –** The College sets and maintain standards of practice that guide our Registrants to ensure they provide safe, ethical and competent patient care and guide patients to understand the standard of care that they can expect from a naturopath.

3. **Ensuring Continuing Competence –** The College creates and manages a variety of continuing education and professional development programs to help assure the provision of safe, competent and ethical naturopathic care.

4. **Providing Accountability through Complaints and Discipline –** The College holds Ontario naturopaths accountable for their conduct and practice by investigating complaints and concerns and determining appropriate solutions, including disciplining naturopaths who have not upheld the standards.

Some elements of the College's role, such as setting standards and ensuring continuing competence, are proactive insomuch as they attempt to prevent issues from arising by setting minimum standards and ensuring a competent profession. Other elements of the College's role, such as registering individuals and holding naturopaths accountable, are reactive, that is, they are initiated only after an event occurs. The event may be a request to sit an exam or to become registered or a complaint that has been filed against a Registrant.

When we do our job well, we have set rules that ensure safe care that benefits patients; we have registered the right people who are qualified and committed to providing safe, ethical and competent care; we have ensured that our Registrants maintain their knowledge, skill and judgement; and we have held those who may have faltered to be accountable for their decisions and actions.

Other elements that will arise within the regulatory framework include "right touch regulation", using the approach that is best suited to the situation to arrive at the desired outcome of public protection,

and risk-based regulation, focusing regulatory resources on areas that present the greatest risk of harm to the public. Both of these will be further elaborated upon in later briefings.

The focus of this briefing is on the Inspection Program and processes of the College.

General Regulation
Part IV of the *General Regulation* made under the *Naturopathy Act, 2007* came into effect on March 1, 2017, and requires the College to conduct inspections in premises where Intravenous Infusion Therapy (IVIT) procedures are performed.

Inspection Program Requirements
The Inspection Program applies to all locations where one or more Registrants perform IVIT procedures. IVIT procedures include:

- The compounding of drugs to make a customised therapeutic product for the purpose of administering by intravenous injection to a patient, or
- The administration of a therapeutic product by IVIT.

The Inspection Program establishes the requirements for a premise and reviews the following areas during inspections:

- Physical environment,
- Emergency preparedness,
- Infection Control,
- Sterile Compounding,
- Administering IVIT,
- Record Keeping and charting,
- Reporting of Type 1 and Type 2 occurrences,
- Delegation, and
- Quality management.

Every premises that is registered and performing IVIT procedures will undergo a scheduled inspection once every five years. Each inspection outcome is posted on the IVIT Premises Register. The outcome can be a “pass”, a “pass with conditions” or a “fail”.

Registering an IVIT Premises
A new premises where IVIT procedures are intended to be performed must be registered with the College, undergo Part I of an inspection, and receive a “pass” or “pass with conditions” that will then allow it to begin performing IVIT. The second part, Part II of the new premise’s inspection, occurs within approximately six months after the Part I inspection is completed.

Subsequent Inspections
After the Part I and Part II inspections are completed, subsequent inspections must occur within five years of the date of the last inspection and every five years thereafter.

Designated Registrant
Every premises must have an ND who is the Designated Registrant. The Designated Registrant is responsible for:

- All Inspection Program related communications with the College,
- Submitting all Inspection Program forms,
- Ensuring the Inspection Program Requirements are met, and
- Paying all Inspection Program fees on behalf of the premises.

Inspection Process

The following outlines the typical inspection process:

- Notification of an upcoming inspection is sent to the Designated Registrant,
- The Designated Registration submits the Pre-Inspection Information and Declaration of a Conflict of Interest form, and the premises Policies and Procedures Manual within 14 days (this is required for Part I and five-year premises inspections),
- Upon receipt, an inspection is scheduled within approximately 30 days of the Designated Registrant being notified of the assigned inspector,
- At the end of the inspection, the inspector provides feedback to the Designated Registrant who may provide additional comments and/or information to the College, and
- The Inspection Committee reviews the Inspector's Report and any additional information provided by the Designated Registrant and delivers an outcome.

Inspection Outcomes

The Committee will determine an outcome that falls into one of three categories:

- "Pass" – all Inspection Program Requirements are fully met or partially met with minor deficiencies,
- "Pass with conditions" – One or more Inspection Program Requirements are not met that could impact patient safety, and
- "Fail" – few of the Inspection Program Requirements have been met or there are significant deficiencies that pose a risk of harm to patients, and the premises must cease providing services.

Inspectors

Inspectors within the Inspection Program are NDs who have met the standard of practice for IVIT and therapeutic prescribing, who are performing IVIT procedures at a premises, and who are specifically trained in the program requirements set out by the Council of the College. All individuals within a premises are required to cooperate with an inspector who has been appointed by the College to inspect the premises where IVIT services are provided.

Inspection Committee

The Inspection Program is overseen by the Inspection Committee, which is a Committee of the Council of the College. The Committee is made up of individuals who are:

- Registrants of the College who have met the standard of practice for IVIT (and therapeutic prescribing),
- Members of the Council, and
- Public Representatives appointed by the Council.

Type 1 and Type 2 Occurrences

Type 1 occurrences are incidents that may or did result in serious harm to a patient in relation to an Intravenous Infusion Therapy treatment. Type 1 Occurrences include:

- The death of a patient following IVIT,
- The death of a patient within five days following IVIT,
- Referral of a patient to emergency services within five days following IVIT,
- A procedure performed on the wrong patient.
- Administration of an emergency drug to a patient,
- A patient who is diagnosed with shock or convulsions within five days of IVIT, and
- A patient who is diagnosed with a disease of any disease causing agent as a result of the IVIT.

Type 1 occurrences must be reported to the College within 24 hours of the Registrant becoming aware of the occurrence. These reports are reviewed by the Inspection Committee who review the information and may require a follow up review and inspection if warranted by the Inspection Committee.

Type 2 occurrences are incidents that may or did result in harm to a patient in relation to the performance of compounding for or administering by IVIT. These include:

- An infection in a patient after the provision of IVIT,
- An unscheduled treatment of a patient within five days of IVIT, and
- Any adverse drug reaction.

Type 2 occurrences must be tracked and documented and are reported to the College annually.

Importance of this Program

The College's Inspection Program ensures continuous quality improvement for all premises where IVIT procedures are performed through the development and maintenance of standards. This helps enhance the safety and quality of care for the Ontarians who choose to access these services.

Respectfully submitted,

Dr. Mary-Ellen McKenna, ND (Retired)
Manager, Professional Practice