How can AHPRA improve compliance of health practitioner advertising?

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The Australian Health Practitioner Regulation Agency (AHPRA) Guidelines for advertising regulated health services\(^1\) were revised and released for public consultation in late 2019. The proposed version, clarifying how practitioners can comply with section 133 of the national law, is welcome.\(^2\) Similarly, the 2019 social media guide that concentrates on ethical behavior during online interaction\(^3\) is a positive step. However, AHPRA’s approach to compliance, and the enforcement of published guidelines, needs greater focus. While elements of their strategy have merit, this editorial highlights inadequacies in its implementation and proposes a potential way forward.

AHPRA’s ‘Advertising compliance and enforcement strategy for the national scheme’, originally published in April 2017,\(^4\) was re-published verbatim in June 2019\(^5\) at the expense of the document’s accuracy (for example, AHPRA now have 15 national boards). The document refers to an initial review period of 12 months. However, data compiled in AHPRA’s annual reports does not clearly indicate whether the enforcement strategy is improving regulated health services’ advertising practices. By way of example, the 2016–17 annual report notes that complaints about advertising rose by 87.1 per cent,\(^6\) however, the 2017–18 annual report presents data differently, making comparison difficult.\(^7\) The 2018–19 report claims a 37.2 per cent reduction in the number of advertising complaints received, although this appears largely related to the decreased activity of one complainant.\(^8\) The 2018–19 report suggests that 100 per cent of registered practitioners became compliant with advertising guidelines when the matter was raised with them, either immediately
or in response to proposed regulatory action, suggesting ‘the effectiveness of the strategy in educating practitioners’. We need to be mindful, however, that the 2018–19 data reflects change made by practitioners in response to a complaint—it does not provide insight into compliance more generally.

AHPRA states that their enforcement strategy ‘...is flexible so we can respond to new or different types of risks, new or emerging ways to advertise, and evolving public expectations.’ Social media advertising is the new norm and the increase in advertising by health practitioners via this medium needs better enforcement. Coupled with a greater reach than traditional advertising, social media content is largely unmediated allowing users to post information regardless of its accuracy, leaving frequent users susceptible to misinformation and skewed impressions. We know from research that social media can inflate a patient’s sense of knowledge about regulated health services while not actually increasing their understanding about how it may meet their individual needs or the risks involved. Specifically in relation to cosmetic surgery, evidence indicates that social media may adversely impact on young women’s healthcare choices.

To be more responsive, AHPRA could consider a number of strategies.

First, where the advertising breach is on social media, AHPRA could use social media to issue a warning, such as adding a comment or post to indicate that the advertisement is inconsistent with their guidelines. This may act as a deterrent and simultaneously signal to the public to be wary of the advertiser.

Second, breaches that are more commercial in nature, and do not directly pose a serious risk to patient health or safety, could be better regulated. Low and high-risk matters could continue to be defined and dealt with as they are currently. A new category of moderate-risk matters could include advertising that is commercially orientated and designed to significantly increase the number of patients undergoing the advertised treatment (generally elective services that are not clinically indicated or for therapeutic benefit). In this category, the volume of individual advertisements (for example, daily posts on a social media platform) would be taken into consideration in addition to their content.

Third, a more proactive approach to monitoring compliance could be introduced, such as a voluntary database of electronic advertising by registered practitioners who would be asked to provide the URL of any website and/or social media platform they use to advertise their services. A random audit of electronic advertising could then be conducted. If a registered practitioner is found to be non-compliant (through the audit or as a result of a complaint received) a warning could be issued with a request to change, similar to the current mechanism for low-risk offences. If a non-registered practitioner is found to be non-compliant, a restriction on advertising could be issued immediately. Practitioners in professions or specialties for which there have been more advertising complaints or where advertising is directed at an identified vulnerable group could be audited more regularly. If a confirmed breach falls into a new ‘moderate risk’ category (commercially driven services), a similar or increased penalty would apply. AHPRA could then report on the audit and its outcomes by profession and medical specialty, including the types of breaches discovered. Better examples of appropriate and non-compliant advertising and educational interventions, specific to medical specialties, could be based on audit findings.

Fourth, reporting of breaches could be improved. AHPRA claims they ‘...are committed to reporting on action taken including through publishing case studies and enforcement outcomes’. Such reporting does not appear to have increased. The most recent case listed on the AHPRA webpage—‘Advertising cases heard by courts and tribunals’—is from 2013. The only ‘case study’ that could be found is in the 2016–17 annual report (AHPRA vs Hance Limboro). At approximately 75 words, it provides no more information than the table entry of the tribunal decision on the website. Publishing examples of actual complaints made about the
advertising of regulated services, and how they are handled, would be helpful to show that AHPRA is investigating complaints and enforcing guidelines. The therapeutic goods advertising compliance annual report is a good example.

It is acknowledged that AHPRA has improved their education resources in relation to compliance with the advertising guidelines over the past two years and recently conducted a pilot audit of advertising compliance for the national boards of chiropractic and dental. While positive, it is hoped that the re-issuing of their compliance and enforcement strategy, unchanged, does not equate to a lack of progress. At the ‘coalface’ the perception is that some practitioners offering cosmetic surgery are clearly crossing boundaries and/or breaching the guidelines without consequence. In turn, more reputable practitioners are disadvantaged.

Disclosure

The author has no financial or commercial conflicts of interest to disclose.

References


2. Health Practitioner Regulation National Law Act 2009 (Qld) (‘The National Law’) and has been adopted with some modifications in all States and Territories: Health Practitioner Regulation National Law (NSW) No 86a (NSW); Health Practitioner Regulation National Law (Victoria) Act 2009 (Vic); Health Practitioner Regulation National Law (ACT) Act 2010 (ACT); Health Practitioner Regulation National Law (National Uniform Legislation) Act 2010 (NT); Health Practitioner Regulation National Law (Tasmania) Act 2010 (Tas); Health Practitioner Regulation National Law (South Australia) Act 2010 (SA); Health Practitioner Regulation National Law (WA) 2010 (WA).


