#AMCOA2023

ANNUAL CONFERENCE
ASSOCIATION OF MEDICAL COUNCILS OF AFRICA
Team Based Care and Regulation for the Attainment of Universal Health Care
Proudly Hosted By: Rwanda Medical and Dental Council

Role of the regulator and the various regulatory models

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Outline

- Regional practices
- International perspectives
- Best practices
- Innovation
- Challenges
- Recommendations

Purpose and scope of regulation of practitioners

- Oversight of education and training
- Setting and enforcement of practice standards
- Registration and licensing of qualifying practitioners
- Quality assurance in training and practice
- Professional conduct
- Management of complaints

IAMRA: Principles in medical regulation

- Accountability
- Fairness
- Feasibility
- Materiality
- Transparency and openness

Medical regulatory models (MRAs)

- Autonomous
- Responsible to government (regional/national)
- Embedded within government
- Hybrid

IAMRA Statement. Independence of Regulation: The Primacy of Patient Safety, August 2021.

Autonomy – what are the criteria?

- Definitions
  - Autonomy: *freedom, self-determination, self-government, sovereignty*
  - Independence: *not being dependent on others; freedom to make laws without being governed or controlled by …; state of wanting or being able to do things …make your own decisions, without influence from others*
- So, is autonomy compromised when government:
  - Appoints members - some or all?
  - Appoints CEO/ President?
  - Funds council/board?
  - Has representatives on council/board
  - Chairs council/board?
  - Council/board resorts under a government department?

Autonomous MRA

- Council/board members are nominated or elected by the profession and then appointed by the appropriate appointing authority
- Chairman / President elected from among the members by the members and appointed by government, as applicable
- Registrar/CEO appointed by Council through an open, market driven process
- Government may second or appoint members for a specific purpose, e.g., representation of government department(s) or related sectors
- Council accounts to legislature but reports to the political line manager
- Usually completely self-funding

Responsible to or embedded within government

- Variable degrees of autonomy due to
  - Ratios of elected vs appointed members
  - Appointment chairman/president by government or secondment of government officials for that role
  - Whole or part funding by government
  - Imposition of professional interest groups by political principals (associations, trade unions)
  - Ability of responsible political principals to call meetings of council as and when they so require
- Hybrid model

MRAs in Africa: Sources of data

- Country-specific founding legislation (as amended) as the primary source of information
- AMCOA reports
- Website entries

South Africa
Health Professions Council of South Africa

Established by Act of Parliament

- Regulation of doctors, dentists and allied health professions in public and private practice
    - *No authority over training facilities*
- Governing body is a council (HPCSA) comprised of 12 constituent boards
- Members appointed by Minister of Health from a list of nominees from the professions and members of the public
    - *No provision for professional associations or unions in the composition*
    - *Minimum 20% of council and board members are lay public*
- Self-funding
- Autonomous, self-regulating and accountable to the legislature but reports to the MoH
- Incorporates ombudsman in the complaints handling and investigation
- *5 - year term for Boards and Council*

Structure of regulatory bodies for doctors and dentists:

Jurisdiction	Composition			Integration	MRA type
	Lay members	**Professional members**	**Gender parity**		
EAC	Yes	Minimum 50%	Yes	Stand-out feature	Autonomous Hybrid
ECOWAS	Yes	Minimum 50%	Yes	Some attempts Regional language differences may be a concern	Hybrid (government funding)
SADC	Yes	Minimum 50%	Yes	Still aspirational	Autonomous Hybrid Embedded

Regulatory bodies for physicians: international perspective

Jurisdiction	Composition: Lay (%)	Composition: Professional Members (%)	Composition: Total Number	Notes
Australia *(Medical Broad of Australia)*	36%	67%	11	Appointed professional members
Canada — *varies across provinces*				All are elected professional members[a]
British Columbia	33%	67%	15	
Ontario	42%	58%	33	
Hong Kong *(Medical Council of Hong Kong)*	14%	86%	28	Includes elected and appointed professional members
Malaysia* *(Malaysian Medical Council)*	0%	100% (with government officials)	33	• Director General of the Ministry of Health is the ex-officio President and Registrar • Includes elected and appointed professional members
New Zealand *(Medical Council of New Zealand)*	33%	67%	12	Includes elected and appointed professional members
Singapore* *(Singapore Medical Council)*	0%	100% (with government officials)	25	• Director of Medical Services is the Registrar • Includes elected and appointed professional members
United Kingdom *(General Medical Council)*	50%	50%	12	Appointed professional members
United States — *varies across states*				Appointed professional members in most states, some by governors others by medical society lists. Public members by governors
Florida	20%	80%	15	
Texas	37%	63%	19	

* With strong government oversight.
Note: The Ministry of Health in China (mainland) is the center of health professional regulation, and there is no lay involvement.
Sources: medical council/board of the relevant jurisdictions

Yam HK et.al. J Med Reg 2016;102(1)

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Emerging trends in medical regulation

- Co-creation of regulations, policies and guidelines between professions to manage scope creep
- Government legislation often required for reform of medical regulation
- Growing practice of including lay public on regulatory bodies
- Commitment to gender parity
- Move away from pure self-regulation towards regional partnerships
- Variability in the registration and licensing of foreign qualified practitioners

Acknowledgement: Chung V et.al. 2016

Summary

Desirable

Composition

- Inclusion of lay members
- Selection of members with critical skills
- Leadership with professional insights

- Council appointment of CEO and staff
- Stakeholders
  - Direct representation of training institutions
  - Professional associations
- Integration of regulation

Threats

- Remuneration/honoraria a potential risk
- Self-funding through annual fees a risk
- Short termism undermines organizational objectives
- No specific requirement for public health practitioners
- Political interference
- Professional associations (± trade unions)

Recommendations

Appreciate local context (legislative framework, fiscal strength and policy, resource constraints)

- Commission a nuanced report on the state of practice in member states
- Facilitate integrated regulation (SADC)
- Explore feasibility of inter-professional regulation in pursuit of UHC objectives
  - *Interprofessional education*
  - *HPCSA model*
- Enhance fitness for purpose of regulatory body (lay, special skills, gender)
- Review funding model in the interests of sustainability

About over-regulation …

"One of the greatest delusions … is the hope the evils in this world are to be cured by legislation".

Thomas B Reech. US House of Representatives, 1886.

"The greatest dangers to liberty lurk in insidious encroachment by men of zeal, well-meaning but without understanding".

Louis Brandels, 1928.

Thank You

ngiyathokoza!

ro livhuwa!

ke a leboga!

enkosi!

dankie!

thank you!

udo livhuwa!

inkomu!

ngiyabonga!

ke a leboha!

siyabonga!