Review of the Health Practitioners Competence Assurance Act 2003

Thank you for asking for the Medical Council of New Zealand (the Council) to provide feedback on the 2012 review of the Health Practitioners Competence Assurance Act (HPCAA). The Council considered your consultation paper at its meeting of 16 and 17 October 2012.

The Medical Council of New Zealand

The Council is a statutory body instituted with the primary purpose to protect the health and safety of the public. It has the following key functions:

- Registering doctors
- Setting standards and guidelines
- Recertifying and promoting lifelong learning for doctors
- Reviewing practising doctors if there is a concern about performance, professional conduct or health and developing plans for improvement.

The Council’s submission is attached. The submission is broken into seven sections, with an appendix that contains a number of supplementary technical amendments. In summary, the Council submits that:

1. The Council’s view of the HPCAA and health workforce regulation in New Zealand
   - Medical regulation in New Zealand is effective, appropriate and provides the ‘right touch’.
   - The key principles that underpin the HPCAA are appropriate, and should remain intact.

2. Changes proposed by the Council
   - A number of technical amendments to the HPCAA will assist RAs in ensuring that public safety is protected, and that this is done efficiently and effectively.
   - The amendments proposed following the 2008 review should be implemented.

3. Challenging the Ministry’s assumptions
   - The discussion document includes some core assumptions, which are not supported by fact. In particular the discussion document lacks understanding of the relationship between employers and RAs, and the roles that these organisations should play in protecting public safety.
4. Future focus
   • Many of the concerns raised in the discussion paper can be met through the introduction of clear and appropriate performance measures for RAs (and employers), and monitoring against these. Performance measures to address some of the concerns raised in the discussion paper could include:
     o Development of, and compliance with, memoranda of understanding between DHBs and RAs.
     o Implementation of scopes of practice that are neither inappropriately broad, nor overly restrictive.
     o That appropriate consultation has been conducted and that the public, employers and the profession have an opportunity to comment on changes to RA policy.
     o That standard-setting for overseas-practitioners is regularly benchmarked to ensure that their qualifications, training and experience are at a level commensurate with New Zealand graduates.
   • The review should consider how telehealth services provided to or from another country should be regulated.
   • Those clauses in the HPCAA that require correspondence in hard-copy should be amended to allow for electronic communication.
   • The Act should be amended to allow a different category of registration for students.

5. Consumer focus
   • The Ministry canvass patients to discover what they need and want to know about the HPCAA, practitioners and RA processes.
   • The current balance between lay and practitioner members on boards be retained.
   • Council elections be replaced with an appointment process that is both transparent and independent.
   • We agree with the general principle that complaints processes should be accessible and transparent, and it may be useful to incorporate principles related to this into the HPCAA. However, making RAs subject to the Official Information Act would be inappropriate because they are not public bodies and such a step would be inconsistent with the intent of the Act.

6. Safety focus
   • Insufficient attention has been paid to the key questions: does the HPCAA protect public health and safety; and how can RAs better protect public health and safety?
   • The Act should be better aligned with other legislation, particularly those laws and regulations that deal with ACC and the supply, prescribing and administration of medicines and controlled drugs.

7. Cost effectiveness
   • The most effective way to lower health sector costs is to improve the quality of care being delivered. Ensuring that RAs take a broad role in improving the standard of care across a profession will lower costs.
   • Technical amendments to the Act will improve efficiency and effectiveness.
   • Greater collaboration between RAs may reduce administration costs; enhance information sharing; increase and improve contact with key stakeholders; allow for better collection of workforce data; and allow better reporting on performance metrics for each profession and any management organisations.
   • New models for regulation of smaller, newer and/or low risk professions may also reduce cost.
   • Adding a workforce mandate to the RAs without ensuring that it meshes with, and does not compromise, the primary purpose of the Act and the role of RAs and without due consideration of the risks, is problematic.
Thank you again for providing the Council with an opportunity to comment. I hope you find these comments useful. If you have any questions please do not hesitate to contact the Council's senior policy adviser and researcher, Michael Thorn, on (04) 381 6793 or at mthorn@mcnz.org.nz.

Yours sincerely,

Philip Pigou
Chief Executive
The Medical Council of New Zealand’s submission on the 2012 review of the Health Practitioners Competence Assurance Act 2003

October 2012
Executive summary

This submission is broken into seven sections, with an appendix containing a number of supplementary technical amendments. In summary, the Medical Council of New Zealand (the Council) submits that:

1. **The Council’s view of the HPCAA and of health workforce regulation in New Zealand**
   - Medical regulation in New Zealand is effective, appropriate and provides the ‘right touch’.
   - The key principles that underpin the Health Practitioners Competence Assurance Act 2003 (HPCAA) are appropriate, and should remain intact.

2. **Changes proposed by the Council**
   - A number of technical amendments to the HPCAA will assist responsible authorities (RAs) in ensuring that public safety is protected, and that this is done efficiently and effectively.
   - The amendments proposed following the 2008 review should be implemented.

3. **Challenging the Ministry’s assumptions**
   - The discussion document includes some core assumptions, which are not supported by fact. In particular, the discussion document lacks understanding of the relationship between employers and RAs, and the roles that these organisations should play in protecting public safety.

4. **Future focus**
   - Many of the concerns raised in the discussion paper can be met through the introduction of clear and appropriate performance measures for RAs (and employers), and monitoring against these. Performance measures to address some of the concerns raised in the discussion paper could include:
     - Development of, and compliance with, memoranda of understanding between DHBs and RAs.
     - Implementation of scopes of practice that are neither inappropriately broad, nor overly restrictive.
     - That appropriate consultation has been conducted and that the public, employers and the profession have an opportunity to comment on changes to RA policy.
     - That standard-setting for overseas-practitioners is regularly bench-marked to ensure that their qualifications, training and experience are at a level commensurate with New Zealand graduates.
   - The review should consider how telehealth services provided to or from another country should be regulated.
   - Those clauses in the HPCAA that require correspondence in hard-copy should be amended to allow for electronic communication.
   - The Act should be amended to allow a different category of registration for students.
5. **Consumer focus**
- The Ministry canvass patients to discover what they need and want to know about the HPCAA, practitioners and RA processes.
- The current balance between lay and practitioner members on boards be retained.
- Council elections be replaced with an appointment process that is both transparent and independent.
- We agree with the general principle that complaints processes should be accessible and transparent, and it may be useful to incorporate principles related to this into the HPCAA. However, making RAs subject to the Official Information Act would be inappropriate because they are not public bodies and such a step would be inconsistent with the intent of the Act.

6. **Safety focus**
- Insufficient attention has been paid to the key questions: does the HPCAA protect public health and safety; and how can RAs better protect public health and safety?
- The Act should be better aligned with other legislation, particularly those laws and regulations that deal with ACC and the supply, prescribing and administration of medicines and controlled drugs.

7. **Cost effectiveness**
- The most effective way to lower health sector costs is to improve the quality of care being delivered. Ensuring that RAs take a broad role in improving the standard of care across a profession will lower costs.
- Technical amendments to the Act will improve efficiency and effectiveness.
- Greater collaboration between RAs may reduce administration costs; enhance information sharing; increase and improve contact with key stakeholders; allow for better collection of workforce data; and allow better reporting on performance metrics for each profession and any management organisations.
- New models for regulation of smaller, newer and/or low risk professions may also reduce cost.
- Adding a workforce mandate to the RAs without ensuring that it meshes with, and does not compromise, the primary purpose of the Act and the role of RAs and without due consideration of the risks, is problematic.
1. The Council's view of the HPCAA and of health workforce regulation in New Zealand

The Council agrees with the statement in the 2007 UK White Paper *Trust, Assurance and Safety – the regulation of health professionals in the 21st century* that “the key principles that should underpin statutory professional regulation [are]:

a) First, its overriding interest should be the safety and quality of the care that patients receive from health professionals.

b) Second, professional regulation needs to sustain the confidence of both the public and the professions through demonstrable impartiality. Regulators need to be independent of government, the professionals themselves, employers, educators and all the other interest groups involved in healthcare.

c) Third, professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professionals as it is about identifying and addressing poor practice or bad behaviour.

d) Fourth, professional regulation should not create unnecessary burdens, but be proportionate to the risk it addresses and the benefit it brings.

e) Finally, we need a system that ensures the strength and integrity of health professionals ... but is sufficiently flexible to work effectively for the different health needs and healthcare approaches ... and to adapt to future changes.”

In the Council’s experience, (b) is particularly important because effective regulation can only occur when the public and the profession has faith in the integrity of the regulator and faith that the regulator reflects their values.

The HPCAA provides for a combined model of regulation that strikes a principle-based balance between profession and public led processes, including governance. This balance helps to ensure the independence of the responsible authorities while allowing them to have a relationship with, and maintain the faith of, both profession and public. This balance allows the medical profession to play an important role in regulatory processes – and the Council relies heavily on their goodwill to fulfil roles such as supervisors, intern supervisors, colleagues providing support by means of a collegial relationship and agents of Council. Professional engagement in these processes significantly reduces cost.

The Council’s view is that the purpose and functions currently outlined in the HPCAA are appropriate, and that the principles outlined in the 2007 UK White Paper should provide the basis for consideration during the current review of health workforce regulation in New Zealand.

The 2008 Ministry of Health review of the HPCAA and a 2010 report by the Council for Health Regulatory Excellence (CHRE) make clear that medical regulation in New Zealand is effective, appropriate and provides the ‘right touch’.

The Council regularly receives feedback from its international colleagues that the HPCAA and the Council provide an excellent model for effective medical regulation.

The Council is confident that not only is it an effective responsible authority (RA), it is also a responsive and efficient one.
2. Changes to the HPCAA proposed by the Council

2.1 Technical amendments

The Council is disappointed that many of the recommendations we made during the 2008 review of the HPCAA were either rejected by the Ministry of Health, or have not been implemented. We would like to resubmit a number of these for consideration during the current review. Incorporating these amendments into the HPCAA should help reduce costs and ensure that RAs operate more effectively. In particular, we would like to highlight our recommendations that:

- There are more efficient mechanisms than regulation where the risk to public health and safety is low. The Council recommends that the current threshold for regulation of new professions be raised and that the Ministry progresses its recent work on reviewing the criteria for regulation.

- Section 37 should be looked at closely with regards to the opportunity for practitioners to be heard in person in relation to a competence review. The competence review process was intended to be a fair, simple, speedy and efficient process, but it is becoming unduly obstructed and expensive through the exploitation of this requirement by lawyers.

- Section 68(2) should be amended to provide RAs with less costly and time-consuming alternatives for action. This section currently requires a Professional Conduct Committee to be convened for relatively minor matters, such as a conviction for some alcohol related offences (e.g. drunk-driving), when a health review would be a more efficient and effective mechanism for protecting public health and safety.

- Section 69 should also be reviewed to allow for immediate suspension of a practising certificate due to concerns about conduct when there are concerns that the practitioner presents a risk of serious harm. This section currently only allows for a suspension to occur after the practitioner has been “given ... a reasonable opportunity to make written submissions and be heard on the question” and this requirement is being exploited and can result in costly delays that present a risk of serious harm to patients.

- Section 144 requires revision. This section makes removing a practitioner from a register too costly, time-consuming and complex.

Other technical amendments which were recommended by the Council as part of the 2008 review, and which are submitted again as part of this current review, are attached as Appendix 1.

In its 2010 review of the Council the CHRE supported, and supplemented, some of these submissions when it recommended that the HPCAA be amended. The Council supports the CHRE’s views that:

- We consider that the legislation is too protective of doctors [...] and that if the Council believes that conditions [or suspensions] are necessary it should be able to impose them immediately rather than propose them to the doctor at the first meeting. (Paragraph 7.12)

- [The HPCAA should be amended with a view to] Reducing some of the doctor’s rights to object to legitimate actions, such as their power to object to the composition of the PCC and to conditions proposed by the Council (Paragraph 7.39).

- [The HPCAA should be amended with a view to] Defining more clearly the thresholds of ‘risk of harm’ and ‘risk of serious harm’. (Paragraph 7.39).

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1 Convening a Professional Conduct Committee is accordance with s.71-83 of the HPCAA is an expensive process. A recent and typical example, involving a straightforward drunk-driving offense where there were no underlying concerns and where the Committee made no recommendations for further action, cost Council $2651.90—and no doubt also created additional expense for the doctor and health service involved.
A copy of the CHRE’s report is available on request.

The Council would also recommend a further technical amendment with regards to the charging of fees. The Act currently only allows RAs to charge practitioners a fee for services provided, but some RAs are involved in accrediting of educational institutions (such as hospitals and medical colleges). At the moment practitioner fees are being used for this purpose, even where the educational facility benefits. It is recommended that the Act be amended to allow RAs to charge a fee to agencies such as educational facilities when they provide accreditation services.

2.2 Improved links with other legislation

The HPCAA does not link particularly well with other pieces of legislation – primarily that which deals with supplying, prescribing and administering medicines and controlled drugs and that which governs the relationship between RAs and ACC.

Supplying, prescribing and administering medicines and controlled drugs

Data outlining a doctor's prescribing patterns provide a valuable source of information about the competence and fitness to practice of prescribers. In many overseas jurisdictions, RAs have direct access to this information and use it both proactively to monitor prescribing behaviours and reactively in the assessment of complaints.

In New Zealand the current legislation makes it the Ministry of Health’s responsibility to collect information about the supply, prescribing and administration of medicines and certain controlled drugs, and the relevant RA’s responsibility to act when an individual health practitioner has supplied, prescribed or administered medicines or controlled drugs in a way that is not consistent with best practice or appears to be themselves’ dependent on a controlled drug.

The current legislation does not allow RAs to appropriately fulfil these latter functions.

The ability of RAs to act on concerns is heavily affected by the information that they are provided by the Ministry of Health and yet the legislation neglects to include clear and directive reporting provisions. Medical Council staff regularly meet with staff at the Ministry’s Medicines Control office to discuss supply, prescribing and administration issues, but formal notification of concerns about individual doctors is uncommon – and Ministry staff have sometimes appeared uncertain about when they are permitted to notify the Council of their concerns, and what information they are permitted to provide.

The reason for this lack of clarity about information sharing in the legislation is likely to be historic. When the HPCAA came into force in 2003 it did not link well with the much older Misuse of Drugs Act 1975. The HPCAA gave RAs the function and powers to investigate concerns about a practitioner’s competence. However, these did not exist in 1975 so the Misuse of Drugs Act provided medical officers of health with a limited ability to investigate matters of competence where it related to the supply and administration of controlled drugs. While the Misuse of Drugs Act was updated to reflect the shift in responsibility that occurred in 2003, neither it nor the HPCAA included appropriate reporting mechanisms. As noted above, the Misuse of Drugs Act explicitly makes RAs responsible for taking action in relation to an individual practitioner’s use of controlled drugs – but the legislation fails to provide the Ministry and medical officers of health with a clear process to provide RAs with information.
In Council's opinion, more effective and efficient regulation of supply, prescribing and administration of all medicines and controlled drugs could be enabled by including more explicit reporting mechanisms in the HPCAA. These clauses could require the Ministry to provide all relevant information to the appropriate RA if it has reason to believe that the practice of a health practitioner may pose a risk of harm to the public. These amendments would allow RAs to fulfil their functions under both the medicines and controlled drug legislation and the HPCAA, and to take action when a practitioner is inappropriately supplying, prescribing or administering medicines or controlled drugs – including to himself or herself.

The relationship between ACC and RAs
In 2001 the Cull report expressed concern about the failure of agencies to share information about health practitioners with one another. Despite the clear and explicit recommendations of that report, ACC has become even more of an information "silo" than it was when that report was published. As Professor Paterson notes in his book The Good Doctor (pages 101-105), ACC holds significant information about the competence and fitness of practice of doctors, but apparently finds it hard to conclude that a risk of harm exists or to make meaningful reports to RAs. The Council currently only receives a handful of notifications from ACC (around 6 per year) and the information provided in these notifications is sometimes inadequate or unhelpful. In the Council's view, the HPCAA should require ACC to notify an RA when it has a concern that a practitioner presents a risk of harm.

2.3 Amending Professional Conduct Committees provisions

The HPCAA currently constrains Professional Conduct Committees (PCCs) in a way that limits their efficiency and effectiveness. We propose that the HPCAA be amended to:

- Remove section 73(4). This section states that the same legal advisor cannot both assist the PCC in its investigation, and represent the PCC before the HPDT. This does not appear necessary and both extends the process (as a second lawyer must be bought up to speed) and increases cost.
- Include a new provision in the HPCAA, similar to s.43, to allow an RA to respond to and enforce satisfactory compliance with a post-PCC order of Council. Under the current Act a PCC can recommend counselling, but an RA has no power to require a practitioner to attend a recommended course or programme.
3. Challenging the Ministry’s assumptions

The discussion paper includes a number of underlying assumptions that need to be challenged. In particular:

**An assumption that regulation is not working**

There appears to be an assumption throughout the paper that health practitioner regulation in New Zealand is not working, or needs to be improved. No evidence is supplied to support this, and the Ministry has not previously raised concerns with the Council. As noted above, the conclusion of both the 2009 Ministry of Health review of the HPCAA and a 2010 report by the CHRE was that medical regulation in New Zealand is effective, appropriate and provides the ‘right touch’. If the Ministry has concerns about the operation of the Council, Council would be happy to receive these.

**An assumption that amending the Act is the only solution**

The discussion paper focuses on questions of how the Act can be amended to improve outcomes. There is an implication in this line of questioning that amending the Act is the only way to effect improvements. In many cases, a more valid and appropriate line of questioning would be “how can implementation of the Act be improved (or assisted) to improve outcomes?”

**A disconnect between the purpose and aims of the discussion document**

The objectives listed under “scope of the review” (page vii) and the purpose of the review listed at the bottom of page 2 appear to be at odds with each other. The first appears to be a list of specific policy objectives, while the second seems to target strategic issues that will ultimately improve public safety.

**An assumption that policy work is antagonistic to regulator efficiency**

On page 2 of the document there is a discussion of the international trends in health practitioner regulation. The third “trend” identified is not obvious and requires clarification. The second sentence of the description (“These latest developments focus on the implications of regulators’ attempts to progress policies rather than managing RAs’ processes”) is also confusing. Moreover, it suggests that RAs don’t have a role in policy development or in influencing or making change. It also appears to be suggesting that any policy work aimed at improving regulatory process is somehow antagonistic to the regulator operating effectively. Finally, it paints a very limited role or vision for the RAs to improve regulatory effectiveness, consumer participation and increased public protection through being thoughtful and strategic in carrying out their statutory role.

**An assumption that RAs are obstructive to change and innovation**

The section on “Future Focus” goes beyond portraying a limited role for RAs, and states that “if the direction in which the health sector is striving to develop the health and disability workforce is not
supported by RAs, there could be consequences for both the public and the health and disability workforce”. The implication is that RAs are obstructive to change and innovation and do not support solutions to workforce solutions. It also implies that public safety should be a secondary issue. Neither of these things is true, and no evidence has been supplied to support these claims.

It is not the role of RAs to implement government policy, and nor should it be. It is their role to protect public health and safety. However, many RAs – including the Council – actively support workforce development where they have a contribution to make.

The issue at stake here does not appear to be the Act, but instead how the Act is being implemented by individual RAs.

In its 2010 report on the performance of the Council the CHRE expressed considerable concern that Council took too much consideration of workforce issues. The CHRE stated that:

“Although legally the MCNZ is independent from government some of its priorities appear to be based on government priorities rather than strict public protection. The attention that the MCNZ puts on IMGs including arranging supervision and additional assessments appear to be primarily focused on workforce issues rather than patient safety. In our view it is important that the MCNZ should ensure that it maintains its independence as a regulator and that all its decisions and priorities should be directed towards maintaining patient safety and improving the quality of medical practice. It is right for it to work closely with government and with workforce planning but only where regulation has a proper contribution to make.”

In response to the statements about the interface between government workforce initiatives and RAs, the Council submits that the overriding interest of health practitioner regulation and RAs must continue to “…be the safety and quality of the care that patients receive from health professionals”, as outlined in the 2007 UK White Paper. The HPCAA and RAs should not become vehicles for implementing government workforce policy, although they should continue to work with government agencies where they have a contribution to make.

It is important that the functions of an RA are clearly stated in law, principle-based and internally coherent. Care should be taken not to take an incremental, reactive approach to the stated functions of RAs without retaining a view of the whole. In our view, any extension of the functions listed in s.118, to include a “workforce role” should not occur unless this role has been carefully tested to ensure that it fits with the RAs’ existing functions.

**An assumption that qualifications and registration processes do not protect public safety**

The document appears to have a very limited view of the role of RAs. In the section on “Future Focus” it refers to the RAs having an “independent role in keeping the public safe through ensuring the competence of health practitioners”. The relevant paragraph continues, by commenting that other RA roles (eg, setting qualifications and assessing fitness for registration) have “influence on the shape of the workforce”. This underplays the significance of prescribing qualifications and assessing fitness for registration in protecting public safety.
An assumption that stringent regulation only adds cost

There is an assumption, which is explicitly stated on page 11, that “the more stringent the regulation, the greater the cost to all involved and the likelihood that less funding is available for services.” This is overly simplistic and incorrect. Good, effective regulation improves quality and helps to direct resources; thereby reducing cost. The Council believes that regulation should be at the “right touch”\(^2\), and that sometimes the cost of an intervention is necessary to prevent an even more serious and costly mishap or injury. It should also be noted that the most expensive aspect of medical regulation relates to the cost of disciplinary proceedings\(^3\), and reducing cost in this area would be difficult to achieve without also limiting the right of practitioners to legal representation and a fair hearing.

An assumption that RAs are accountable to DHBs because DHBs have agreed to pay some practitioner fees

On page 22 it is stated that “Many of the costs of regulation fall directly on employers, who have little input into the decisions made by RAs that might have cost impacts on them. These costs include practising certificate fees and continuing education requirements...”. There is an assumption throughout the discussion document that because employers meet some of these costs, RAs should be accountable to them and they should have input into RA decision-making.

The reason that some employers meet these costs is in the employment agreements that DHBs have negotiated with health practitioners. Payment of these costs should therefore be considered as part of a practitioner’s remuneration package, and not an “additional cost” imposed on the employer by RAs. RAs charge practitioners, and if practitioners seek reimbursement from their employer then that is a matter between the practitioner and the employer. We note that this type of contractual arrangement is not common overseas. The Ministry’s line of argument, by extension, suggests that because organisations like the Council or the Ministry of Health employ lawyers and pay for their practising certificates, those organisations should have a say in the operation of the Law Society.

It also needs to be noted that around 40% of doctors do not work for a DHB.

While RAs do have an obligation to ensure that health practitioners are competent to practise, to be careful stewards of health practitioner funds, and to consider the impact of its decisions on the workforce – those obligations do not in turn create a responsibility to ensure that DHBs have an input in decision-making other than through appropriate consultation mechanisms.

We note, finally, that DHBs do have a direct obligation to RAs but this obligation is sometimes poorly met. RAs such as the Council provide funding to DHBs to provide staff resource and time to meet our needs, particularly in areas such as supervision of international medical graduates and interns.

\(^2\) ’Right touch’ is a term used by the CHRE to describe regulation that is ‘based on a careful assessment of risk, which is targeted and proportionate, which provides a framework in which professionalism can flourish and organisational excellence can be achieved.’

\(^3\) In recent years Council has been faced with costs of over $1,000,000 in assessing, investigating and prosecuting one practitioner, and an additional $750,000 dealing with a second doctor who presented a serious risk to public health and safety. We are aware that other authorities have faced similar costs in relation to individual practitioners. It is likely that there will continue to be cases like these in the future.
4. Future focus

Workforce development and the purpose of the HPCAA

This section of the discussion document states that “The core safety function of the HPCAA needs to be balanced against ensuring that its indirect (but strong) influence on the shape of the workforce matches the needs of a changing sector.” As noted above, the Council strongly challenges some of the underlying assumptions made here—primarily that: RAs have no role (or even worse, act as a brake) in changing and improving health workforce policy; that the public protection role of RAs should be watered down; and that RAs have an obligation to employers because they have agreed to pay some practitioner fees.

The Ministry seeks feedback on “… whether the Act, or how it is operationalised through RAs, needs to include mechanisms that better recognise the complex environment that health professionals work in.”

Recognition of the complex health environment is provided in the memorandum of understanding (MoU) that the Council has developed with DHBs. MoUs are also being developed with private hospitals and the primary health sector. These MoUs are intended to:

- Define roles and responsibilities and encourage positive relationships.
- Clarify regulatory and employer processes regarding individual practitioners.
- Promote the sharing of information.

Because RAs can (and have) already developed such mechanisms, it does not appear that the HPCAA needs specific amendment on this point.

Steps to be taken to future proof the Act

Performance measures

During the 2008 review of the HPCAA the Ministry of Health recommended that performance indicators be developed and that RAs be assessed against these. The Council would support the introduction of external performance assessment of RAs, and suggest that the development of, and compliance with, of MoUs between RAs and DHBs be included as a performance indicator for both sets of bodies.

Telehealth

In future proofing the HPCAA the Council submits that the Ministry should address a specific issue that is likely to become increasingly important in the future, and which is currently dealt with poorly in the HPCAA. In particular, we recommend that the Act be clear on expectations for the regulation of practitioners based overseas, but providing telehealth services to New Zealand based consumers.

The Council’s view is that the Act must protect the health and safety of all patients located in New Zealand, but greater flexibility may be needed to allow RAs to use alternate measures to ensure that

4 The Council has already developed a range of key performance indicators, such as time to completion of registration tasks, that it uses internally to monitor and assess performance.
practitioners who are located in another country are competent and fit to practise and there is no risk of harm to New Zealanders receiving telehealth services.

We note that the Act appears to require all doctors who provide services to New Zealand based patients to be registered with the Medical Council of New Zealand. Some international legislation works differently (in the UK the GMC is required to register doctors who are located in the UK) and these differences may create duplication and gaps. For example, a radiologist located in the UK and providing services to New Zealand patients is required to be registered in both jurisdictions, while a radiologist located in New Zealand and providing services to patients in the UK need not be registered in either.

**Permitting electronic communication with practitioners**

To modernise the Act, and improve cost-effectiveness, it is also recommended that those sections which require correspondence in hard-copy (such as section 33, section 144, the sections that outline the process for making an application for registration and practising certificates, and the Regulations that relate to elections) be amended to allow for communication to occur electronically.

**Registration of students**

We also submit that the Act be amended to provide for the registration for students. This is needed to ensure, for example, that information about the conduct of students is passed to the regulator.

Council suggests that student registration might be best achieved by creating a separate category of study health practitioner registration. The benefits of this approach would include that:

- Students are not captured by some unnecessary parts of the legislation, for example those provisions to do with competence.
- Students do not, if registered, become subject to other legislation that may be irrelevant or inappropriate. For example, it would not be appropriate for a medical student to be able to supply controlled drugs as a registered doctor is permitted to under the Misuse of Drugs Act.

**Health practitioners working in teams**

This section states that “Tensions can occur when introducing new procedures or models of care that require closer, more integrated ways of working across traditional health professional boundaries.”

The Council agrees, but notes that passing new legislation is unlikely to result in improved team function. Instead this is something that professions and regulators should address through the development and refinement of scopes of practice, and by giving careful consideration to how these relate and overlap.

This section further states that “Improving inter-professional communication and collaboration, particularly in relation to spoken and written communications and handover of care, is vital to improving the quality and efficiency of health and disability services.”

The Council agrees with this sentiment too, but improving communication and collaboration between practitioners cannot be achieved through legislation. It should also be noted that an increase in inter-professional communication and collaboration has been a feature of the HPCAA era, and the legislation can therefore hardly be held up as a barrier to this.
The Council is carefully considering issues of communication and handover as part of its review of Good Medical Practice and has drawn heavily on the standards developed by other authorities (notably the Nursing Council, the Dental Council and the Pharmacy Council) in this work.

It is also important to acknowledge that the Code of Health and Disability Services Consumers’ Rights already provides a common basis for health practitioner standards – including as they relate to matters such as co-operation between providers (Right 4), communication (Right 5) and informed consent (Rights 6 and 7).

**Information contained in scopes of practice**

This section notes that “some professions have chosen to publish prescriptive scopes of practice that provide detailed information about what practitioners can do” and goes on to state that such detailed scopes of practice “risk becoming too rigid and out of date”. In contrast, the discussion paper notes that “broad scopes of practice [increase] the flexibility that health practitioners have in terms of how they describe what they do and allows for easy amendment.”

The Council largely agrees with this sentiment, but notes that it conflicts with a statement on page 5 of the discussion paper that “health practitioners can struggle to reconcile working with blurred boundaries...” Scopes of practice which are too broad and flexible risk becoming meaningless in terms of ensuring that practitioners work within their field of expertise, hold appropriate qualifications, meet appropriate standards and remain competent. It is also important to note that the Council has a “general” scope of practice (which most doctors practising in New Zealand hold). This scope allows a doctor to work in any area of medicine subject to recertification / collegial relationship requirements.

The solution to the issue of inappropriately broad or restrictive scopes of practice does not appear to lie with legislative change, but should rather be treated as a performance issue for individual RAs.

The specific question asked in the discussion paper on this subject states “Do we have the right balance between broad scopes of practice and providing sufficient information to inform people about what they can expect from a health practitioner?” This question appears to confute two different questions, 1) are scopes of practice working as intended, and 2) do patients have sufficient information and understanding to make an informed choice about who they see for care? It is suggested that while scopes of practice may sometimes provide one part of the answer to the second question, patients actually obtain information about practitioners from a wide range of different sources. Enabling patients to make an informed choice is much more complex than simply improving the wording of scopes of practice. Rather than assume that the public makes choices about which practitioners to see based on title (as a vestige of the old licensing approach to regulation) or based on the content of scopes of practice, Council considers that some research into how the public makes choices of providers might be valuable. In answering this question, therefore, the Council recommends that the Ministry consider all the sources of information that are available – or could be available – to the public and which could help them in making decisions about their care.

The Council’s consumer advisory group also recently raised concerns about informed consent, and understanding the skills, knowledge and expertise of practitioners who provide care to them in hospitals. We would be happy to work with the Ministry, the Health and Disability Commissioner, and other RAs, to address these concerns.
Improving the pastoral care of health practitioners

The discussion document states that the Act does not currently require RAs to provide pastoral care, but asks if that should change. It suggests that “Pastoral care could involve RAs ‘walking alongside’ health practitioners, supporting them through times of stress by recognising and acting on signs of practitioner distress, maintaining the dignity of practitioners during any complaint process, and providing support.”

Council would not support this suggestion. We are concerned that the proposal is overly simplistic, not supported by any substantive analysis, and fails to address the possible consequences of the proposition.

There is some correlation between what the Ministry calls “pastoral care” and how the Council manages doctors with a health concern. However, the primary role of RAs must continue to be to protect the public. Practitioners already have a number of avenues where they can obtain pastoral care, including from their employer or from organisations such as medical colleges and the Medical Protection Society. While a good regulator acts with due care and compassion, there is a danger that requiring a regulator to provide pastoral care may result in “regulatory capture”\(^5\) — and that in focusing on care of the practitioner, the authority may neglect its responsibility to protect the public.

We would support the comments of Professor Paterson in The Good Doctor where he states that “Remediation of doctors, though an important aim, should not obscure the overriding goal of protecting the public by ensuring proper standards in the practice of medicine.” In the Council’s view there must continue to be clear divisions between the duties of an employer to provide for the needs of employees, the role of practitioner associations to act in the interests of their members, and the duty of a regulator to take action when it is necessary to protect the public.

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\(^5\) A term used to describe the situation where a professional body begins to identify more with the people it regulates than it does with the people it is supposed to protect.
5. Consumer focus

Public understanding of the HPCAA

This section asks “Does the public sufficiently understand how the HPCA Act works and the role of individuals in keeping themselves safe from harm when accessing health and disability services?”

In response to this section it is important to note that the last review of the Act resulted in a recommendation that “the responsible authorities and the Ministry of Health do more to inform the public about the HPCAA through their websites, publications and other means, including making business information about registered practitioners freely available.” Since this recommendation was made most RAs, including the Council, have included a section on their website for members of the public. The Ministry of Health has also updated its website to provide information about the Act for consumers. The RAs also updated an information pamphlet to inform the public about their role and the HPCAA.

In answering the question posed in the discussion paper it is important to have an understanding of what information patients actually need and want. For example, do they need or want to know what the Act says and how it works? Or do they need and want to know what their rights are, who is accountable and where to go when something goes wrong?

The Council recommends that, as part of this review, the Ministry canvass members of the public to discover what they need and want to know about the HPCAA.

Public involvement in decision-making

The section of the discussion paper on “public involvement in decision-making” asks “do we have the right balance of laypeople to health professionals on RA boards?” This question was also posed by Professor Ron Paterson in his book The Good Doctor and a discussion of this issue can be found in pages 158-160 of that book.

The Council would have concerns if the balance of Council members were to be adjusted too far in favour of lay members. This is because such a change would reduce the level of medical expertise on the Council, which would result in an increase in the use of medical advisers, greater use of sub-committees and an increase in the costs to practitioners. It is also important to note that New Zealand is a small country, and medical members often have to excuse themselves from discussions about individual doctors because of a conflict of interest. The current balance works well.

The Council would also highlight that adding additional lay people to a Board may not necessarily result in “public involvement in decision-making”. While lay members bring perspective, alternative views and governance skills they do not usually provide an avenue for general members of the public to be involved in making decisions. It is likely that improved public consultation, engagement and transparency of information of processes provide better avenues for achieving this aim.

Professor Paterson states that “No places on the [Medical Council] should be reserved for election by the profession. The job of a regulator must be clearly seen to be to regulate the profession in the
public interest, not on behalf of the profession.” The Council supports this position. Elections served a purpose to allay practitioner concerns while the new legislation was being implemented, but they reflect a model of self-regulation rather than of co-regulation and are therefore not consistent with the intent of the Act. The Council also submits, however, that before elections are eliminated a transparent and independent appointment process must first be put in place.

The Council supports Professor Paterson’s view that appointments should “...be made through a transparent and independent process, with members appointed for their skills in governance and their ability to contribute to the performance of the public protective functions of a regulator.” We note that this view was also expressed by the CHRE during its 2010 review.

The Council also urges the Ministry to consider length of term in the appointments process. It is important to ensure continuity of knowledge and experience on boards, and therefore short-term appointments should be avoided, particularly where good succession planning in RAs is a goal.

This section of the discussion paper also asks “How can the public be sure [qualifications, scopes of practice and competency standards] are set at the right level to keep the public safe and not set at a higher level to meet the interests of the profession rather than to ensure public safety?” The Council actively engages with the public on the level of regulation it provides (through three-yearly surveys and through its recently established consumer advisory group).

Again, this section implies that more stringent regulation results in less funding for services. This is a misleading premise, with nothing in the document to substantiate the assertion. As noted above the Council does not agree with that view.

**Transparency of information and processes**

This part of the discussion paper states that “complaints processes should be accessible and transparent” and that consumers currently “cannot review RA decisions or find out information using the Official Information Act 1982.” The Council asks in reply, what information do consumers want to obtain that is not already available? The discussion document is silent on this, and it is not clear to the Council what research the Ministry has undertaken on the point.

In response to the report by the CHRE in 2010 Council resolved to be more open with consumers than it had been, although it did not go so far as to advocate for RAs to be subject to freedom of information laws. In 2010 Council resolved to:

- Work to a general principle that information about Council’s decisions should be publicly available when any formal order or direction is made.
- To include more information on the public register.
- To cease using voluntary undertakings except for the purpose of the health team or where this is a temporary measure until a formal order or direction can be made. This decision was made in part because voluntary undertakings are a confidential measure and in part because of difficulty in ensuring compliance, and their use should therefore be strictly limited.
- Notify informants of the outcome of decisions made in relation to concerns.
- Investigate whether informants should receive update letters, for example to advise them that a matter has been referred to a PAC and they will be advised of the outcome at a later date.
- Document and make available on request the Council’s appointment processes for agents and Committee members.
- Issue media releases to advise the public and profession when Council releases new statements and resources.
This section of the discussion paper also discusses the use of "consumer forums, where the public can communicate with RAs on matters that concerns them". As noted above, the Council engages with the public through its consumer advisory group and through three-yearly surveys of the public.

The subject of the accountability and public oversight of RAs is a complex matter. RAs are subject to audit by the Office of the Auditor-General and review by Parliament, but are not subject to the Official Information Act or the Office of the Ombudsmen. Excluding RAs from these latter pieces of law was a deliberate decision of principle by policy makers and Parliament when drafting the legislation and should remain extant. It is part of the social contract that RAs operate within – applying health practitioner funds for the good of the public. Underpinning this approach is that the Medical Council and other RAs do not receive public funding.

The Council agrees with the general principle that complaints processes should be accessible and transparent, and it may be useful to incorporate principles related to this into the HPCAA. However, making RAs subject to the Official Information Act would be inappropriate because they are not public bodies and such a step would be inconsistent with the intent of the Act.

As noted above, it is not clear what information consumers want to obtain that is not already available. It is suggested that if there is a concern that information is not accessible, then some analysis of the lack should be done, and of the additional processes and costs that would be involved in meeting this lack.

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6 As discussed above, the Council rejects the argument that because DHBs refund doctors the cost of their practising certificates the Council receives public funding.
6. Safety focus

How the HPCAA works within the health system

This part of the discussion paper states that “…there are other legislative mechanisms that are concerned with risk management, and so it is necessary to consider how the HPCA Act contributes to the overall system of government regulation. Also, the role of professional regulation in safeguarding the public is supported and complemented by the responsibilities of employing organisations”. The paper goes on to ask “…if employers already have systems in place for groups of health professionals to keep the public safe from harm, what additional value does statutory regulation have in this situation?”

There are certainly some situations where alternative, employment-based, systems of regulation have real value in protecting the public and where additional external regulation has limited value. One example might be in the regulation of roles such as anaesthetic technicians, where practitioners only operate under the supervision of an anaesthetist. However, it is important to note that:

- Employers do have a clear conflict of interest. This is especially true in the current economic climate where there is pressure on employers to increase service delivery with limited funding.
- Having good HR practices is not the same as having robust registration, competence, conduct and health processes. Standards, processes and levels of risk management are also highly variable between individual DHBs.
- Since 2001 credentialling has been available as a tool for DHBs. In theory credentialling should provide a useful complement to external regulation, but DHBs are not required to have credentialling processes and it is used inconsistently, and sometimes not at all.
- Not all employers are DHBs. Many health practitioners work in private practice or within a PHO. Many employers do not have the infrastructure or resources to develop and enforce strong standards, HR processes or risk management systems.

The Council supports the development and improvement of employment-based risk management processes (including credentialling) as a complement to, and not an alternative to, external regulation. In our view, such employer-based systems should focus on providing lower level “soft” (or potentially even “pastoral”) regulation with a clear process for escalation to RAs when “hard” regulation is needed. The Council has established a memorandum of understanding with DHBs which outlines the division of the responsibilities of the regulator and employer for the 60% of doctors employed in DHBs. We are currently developing a separate memorandum of understanding for those doctors employed within the larger private hospitals.

Discussion

The discussion document does not give sufficient attention to public safety, and fails to ask the key question “Is the HPCAA effective in protecting public health and safety?” It also fails to ask “How can RAs better protect public health and safety?”

It is important to make clear that RAs are not just licensing agencies. They have a broader role in protecting public health and safety. This role includes acting in a proactive manner where a risk of harm may exist and to raise standards across a profession, rather than simply responding after adverse events have occurred. This quality improvement aspect of the work of RAs has a positive
benefit for the broader health sector. As the quality of care improves, costs come down. And if quality drops, then costs increase.

The Council is currently considering ways that a regulator can proactively identify doctors who may present a risk of harm to the public, and to take action to minimise that risk. This work includes implementing a comprehensive recertification programme for doctors it considers “at risk” (doctors registered in a general scope of practice). The Council is also considering whether it can incorporate more comprehensive screening processes for other more specific “at risk” groups into its existing processes, including: doctors practising in isolation; doctors with a higher number of complaints than average; doctors with unusual patterns of prescribing; and doctors who are still in practise 30+ years after qualifying.

The Council is concerned about one specific area of the Act which does not provide adequately allow for the protection of public health and safety. As noted in the introduction, the requirements of section 37 and section 69 do not allow the Council to act with appropriate speed when it believes that a doctor presents a serious risk of harm due to concerns about his or her competence or conduct. We strongly recommend that the HPCAA be amended to allow RAs to immediately suspend a health practitioner when there is a serious risk of harm to the public as a result of conduct of competence issues.

As noted in the introduction, the Council also recommends that the HPCAA be better aligned with legislation that deals with the supply, prescribing and administration of medicines and controlled. As discussed, clear reporting mechanisms are needed to ensure that those who collect information about use of drugs and medicines (primarily the Ministry of Health) can provide that information to RAs when there is a risk of harm.
7. Cost effectiveness

This section begins with the assumption that:

- Intervention by government in occupations should generally only be used when there is a problem or potential problem that is either unlikely to be solved in any other way or is such that it is inefficient or ineffective to solve in any other way.
- The amount of intervention should be the minimum required to solve the problem.
- The benefits of intervention must exceed the costs.

The Council agrees with these assumptions, and they are consistent with its own aim of providing “right touch” regulation.

Risk framework underpinning the HPCA Act

This section notes that there is no definition of “risk of harm” and “risk of serious harm” in the HPCAA. It notes that RAs have been forced to develop their own definitions and provides the Council’s definitions as an example.

In its 2010 review of the Council, the CHRE also recommended that the thresholds for “risk of harm” and “risk of serious harm” be more clearly defined in the HPCAA. Many other RAs have adopted the Council’s definitions for these terms, and that to ensure consistency and transparency it may be useful to examine incorporating these into the Act.

Regulatory options to manage consumer risk

The discussion paper further looks at the subject of risk management by asking:

- Whether different levels of regulation need to be available to better reflect the risk associated with professional practice?
- Whether other forms of regulation could be sufficient to protect consumers from harm for some health professions?
- Whether work-based supervision or oversight by more experienced professionals is sufficient for some professions?
- How to best support and formally recognise self-regulation as an alternative to statutory regulation, where the risk to the consumer does not warrant other forms of regulation?
- Whether lessons can be learnt from regulatory practices in overseas jurisdictions and also from self-regulating professions in New Zealand.

As noted above, the Council submitted during the 2008 review that there are more efficient mechanisms than regulation where the risk to public health and safety is low and recommended that the current threshold for regulation be raised. Our position on this subject remains the same. We also note that different professions don’t just present different levels of risk, they also present different types of risk. For example, a surgeon presents a risk of physical harm – while a practitioner who works in sole practice with mentally vulnerable patients works with different types of risk and may require different types of intervention.
The status of the Ministry’s work on regulatory thresholds is not clear. The Council would support that work continuing.

Could we improve the cost effectiveness of the HPCA Act? Balancing the cost of public protection with access to services

These two sections of the discussion paper repeat the sentiment made in the section on “Public involvement in decision-making” that regulation “imposes costs on ... health practitioners, consumers and the sector ... and may reduce the funding available for services.” As noted above, the Council challenges this assumption. We also challenge the claim made in this section that RAs should be accountable to employers because employers fund them through payment of registration fees and funding of education programmes.

On the wider issue of reducing cost:
- Improved quality reduces costs to the broader health sector and lower quality raises cost. Ensuring that RAs take a broad role in improving the standard of care across a profession will lower cost by improving quality.
- We refer you to the technical amendments proposed in the introduction to this submission that are intended to improve the effectiveness and efficiency of RAs.
- Greater collaboration between RAs may reduce administration costs; enhance information sharing; increase and improve contact with key stakeholders; allow for better collection of workforce data; and allow better reporting on performance metrics for each profession and any management organisations.
- New models for regulation of smaller, newer and/or low risk professions may also reduce cost. This might include those models discussed in Appendix 4 of the Ministry’s discussion paper (pages 45-50) and also:
  - A model, suggested by the UK’s Department of Health in a July 2006 report on The regulation of the non-medical healthcare professions, whereby larger regulators become “lead regulators” for smaller and newer professions, particularly in situations where most members of the new profession have come from an existing profession.
  - Introducing a second tier layer of regulation (for example, using the simple registration regime discussed on pages 46-47 of the discussion document) – alongside provisions such as those in section 9 of the HPCAA to prevent non-registered practitioners from performing specified restricted activities.

This part of the discussion paper also notes that only one section of the current Act (s.13, which deals with qualifications) requires RAs to balance the costs and benefits of regulation. This section states that “...qualifications must not impose undue costs on health practitioners or the public”. The Ministry questions whether other parts of the Act should include a similar requirement.

The clause in s.13 is relevant in the context of qualifications, because all practitioners are required to hold qualifications and restrictions on these will have an impact across the sector. However, it would not be appropriate to include similar requirements in areas such as conduct or competence, where interventions are tailored to an individual practitioner and the risk of harm that practitioner presents to the public. We also note the link between s.13 and the Minister’s power of audit outlined in s.124. Given the deliberate (and reasonable) decision to set the Minister’s power of audit at a high level we question whether the intention of including additional s.13-like provisions is to provide the Minister with more audit powers, including specific powers to audit RA decisions at an operational level. If this is not the intention, then it is not clear what processes would be
incorporated to support the inclusion of s.13-like principles into areas of the Act that deal with operational decisions about individual practitioners.

We also note that RAs are already subject to oversight by the Office of the Auditor General and Parliament and that this includes careful review of the fees they set by the Office of the Auditor General.

One mechanism to ensure better public and professional oversight may be to include more robust requirements around public consultation. This would allow the public, employers and the profession with a better opportunity to comment on interventions proposed by RAs. This could be accomplished by either amending the Act, or by introduction of a specific performance measure for RAs.

This section of the discussion paper also discusses the recommendation of the 2008 review that performance indicators for RAs be developed and implemented. The paper notes that this has yet to occur, but that both the Medical Council and Nursing Council have been independently reviewed by the CHRE. As discussed above, the Council supports the introduction of performance indicators, and also believe that consideration should be given to the introduction of an oversight body such as the CHRE. Other sections of this submission identify a number of specific areas where the introduction of RA performance measures may be more effective (and efficient) in achieving change than amendment to the Act.

Importance of data collection systems to inform sector intelligence and planning

This part of the paper points to a perceived need for “more formal mechanisms to support the Ministry’s need to access data that will help to understand current and future workforce requirements and identify where shifts in workforce volumes are required...”. The section also states that “...access [to workforce data collected by RAs] can be constrained by how the Privacy Act is applied.”

However, in response to these comments, the Council notes that:

- Workforce data collection is not currently defined as a function of authorities as defined in section 118 of the HPCAA.
- The discussion document lacks any substantive analysis of the argued difficulty in collecting data. Beyond indicating that the RAs could collect more information, the document is unclear on how an obligation to provide the information will be imposed on practitioners, or enforced. Council notes that a failure to provided information in respect of an application is sufficient reason for an RA to decline to process an application. This is a clear and crucial right given to RAs. Linking the obligation to provide the Ministry with workforce information with the obligation to provide information required by an RA has the potential to create significant problems. It would not be lawful (or even appropriate) for the RA to decline to consider an application for a practising certificate on the basis that the applicant has not provided information required by some other agency for the purposes only of those other agencies. Council questions whether its role is to police and enforce compliance with the non-regulatory requirement of a government agency. Council is unsure whether the Ministry has fully analysed the implications of this proposal.
- Council staff have taken part in a number of discussions with Ministry of Health staff over the past few years and have expressed a willingness to develop a survey that improves on the

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7 However, it must be acknowledged that in increasing the requirement to consult there will automatically be some increase in cost due to the additional resource required to run a consultation process.
granularity of data on the types of work performed by doctors, as well as linking to historical data collections across the responsible authorities to investigate better methods of data collection. Council has never received a response to these suggestions.

- Data collection and analysis could be improved by aligning and improving the surveys conducted by each responsible authority and to improve the level of funding.
- Cost-savings could be achieved by responsible authorities entering into joint-purchase agreements or role-sharing with regards to survey design and data collection.
- Addressing the constraints imposed by the Privacy Act can largely be met by advising practitioners on how data will be used before that data is collected. This does require the Ministry to advise RAs of the type of data they will need before workforce data is collected. As noted above, the Ministry of Health has not been effective at communicating its data needs to the Council.

**Increasing standardisation across professional groups**

This section notes that “The advantage of having 16 RAs is that they are responsive to individual professions. However, because each RA differs in the way it carries out its responsibilities, there is variability and fragmentation of professional standards and information.” It discusses the option of “clustering” some RA secretariats and notes that “Work is underway in New Zealand to establish a shared, consolidated secretariat that supports the regulatory functions of all RAs.”

The Council is continuing to work with other RAs to develop a detailed business case for a shared secretariat, covering all regulatory and administrative support functions currently undertaken. We will consider the costs, risks and benefits to the Council of any shared secretariat model once the detailed business case has been finalised and prior to making a decision to join such a secretariat.

The only specific question posed in this section is “Should the number of regulatory boards be reduced, as in the UK?” As noted above, the Council has previously submitted that the threshold for regulation be raised, and that they may be more effective ways of ensuring public safety when the risk of harm is low.

**Size of RA Boards**

This section notes that the CHRE has recently recommended that the optimal size for a board in the UK is 8-12 members, and also briefly touches on the fact that regulations provided for both the Medical Council and Nursing Council to have elected members.

As discussed above, the Council’s view is that a clear and transparent appointments process should be put in place and that once this has been implemented then no places on a board should be reserved for elected members.

**Improving employers’ ability to manage cost impacts**

This section of the discussion document again discusses the perceived imposition of costs on employers, and provides as an example “the RA standard setting for overseas-qualified health practitioners wanting to work in New Zealand”. The section concludes that “Mechanisms need to be explored that would prompt RAs to further consider the wider cost impacts of imposed requirements, and to provide frameworks and other tools to balance the costs and benefits of regulation.”
As already noted, the Council strongly refutes the implication that RAs owe any direct obligation to employers. In our view the focus of the HPCAA should remain the protection of public health and safety, and we again refer you to the CHRE’s recommendation to this effect. However, although RAs do not - and should not - have any direct duty to consider the needs of employers, they do have an indirect duty to employers in that they are responsible for ensuring that their employees are fit and competent to practise – and an obligation to the profession being regulated to be careful stewards of the fees they pay. As suggested above, the Ministry might consider whether to amend the Act to include more specific requirements around the consultation processes that RAs should follow.

We also note that there are already mechanisms RAs can use to ensure that they address issues of risk appropriately, in particular as they relate to “the RA standard setting for overseas-qualified health practitioners wanting to work in New Zealand”. The Council regularly reviews its registration pathways. The approach we take is to use the qualifications, training and experience of New Zealand-qualified practitioners as our default measure / benchmark, and is employed to ensure that the threshold for registration of overseas-qualified practitioners is set at a level commensurate with the local graduate. We are confident that this system is robust.

The Ministry might consider that implementation (and appropriate use) of such a system should be introduced as a key performance indicator for RAs.

The Council also does regular environmental scanning to review and consider the developments in other jurisdictions, and again the Council is very confident that our approach reflects international best practice.
Appendix - Technical amendments to the HPCAA proposed by the Council in 2008, and resubmitted in 2012

- There are more efficient mechanisms than regulation where the risk to public health and safety is low. The Council recommends that the current threshold for regulation be raised.
- Section 37 should be looked at closely with regards to the opportunity for practitioners to be heard in person in relation to a competence review. The competence review process was intended to be a fair, simple, speedy and efficient process, but it is becoming unduly obstructed and expensive through the exploitation of this requirement by lawyers.
- The triggers for action by authorities in section 34, section 35, section 9 and section 93(1) should be better defined. In particular, it is submitted that the threshold for “serious harm” as defined in section 39 is too high. For example, it does not allow for an RA to take action if a practitioner practises in a manner inconsistent with conditions.
- The Act should require ACC to provide information to the Council when it has concerns that a practitioner is unable to perform their required functions because of a mental or physical condition, or when it has concerns about a practitioner’s competence. It is noted that the lack of information sharing was a major focus of the report made by Ms Helen Cull QC during her review of processes concerning adverse medical events in 2001. Despite the very specific recommendations made in Ms Cull’s report, the Council receives significantly less information from ACC today than it did in 2001. In our view, this failure to share information creates a significant risk of harm.
- There should be greater consistency in the use of language between section 39, section 48 and section 69 (which discuss “suspension of practising certificate”), and section 50 and section 93 (which discusses “suspension of registration”). These two terms do mean different things and therefore require separate processes, however Council would prefer the same term to be used in all cases to prevent the duplication of processes.
- The Ministry should consider whether the criteria outlined under s.16 are sufficient to allow an RA to make an appropriately informed decision about a practitioner’s application for registration. For example, under the current wording s.16 does not allow an authority to deny registration to an applicant who has provided misleading or false information during the application process.
- Consideration should be given to how the Act allows for the practice of telemedicine. Teleradiology is already common in New Zealand and a broad interpretation of the Act would require those providing telemedicine from another country to be registered to practise in New Zealand. While this might be a reasonable expectation, practical application of the provisions of the Act (and other related legislation) is problematic.
- The requirement in 38(3) that a copy of an order be given to parties within 5 working days of being made is not practicable. Ten working days appears more appropriate and achievable.
- Section 43(1) should be amended to allow a practitioner’s scope of practice to be changed AND for conditions to be put on their practice as a result of unsatisfactory results from a competence or recertification programme. Currently this section only allows one or the other to occur and Council has had situations where both would be appropriate.
- The Council submits that there should be greater consistency in how the sections in the Act on competence, conduct and health deal with reporting. Section 45 should be the model for the notification of conduct and competence related matters, as well as mental and physical conditions. In addition these sections should all require those who are funders or partners of health practitioners to report concerns. At the moment the requirement that just “employers”
meet this obligation creates gaps in private practice and for those working in the PHO environment.

- Section 45(5) requires providers of education programmes (for example medical schools) to notify Council when a student is unable to practise medicine because of a mental or physical condition. Council would like to see this expanded to include conduct and competence related matters. Council understands that the medical schools would be supportive of this change.

- Section 46 should not be limited to just "medical advice". There are situations in which advice from non-medics is more appropriate (particularly where a neuropsychosocial assessment is needed).

- Section 49(2)(a)(i) and section 49(6) should be reworded to provide greater scope because it is often not possible to identify a single condition which may make the practitioner unable to perform the functions required to practise. Council has often faced the situation where multiple causes (such as substance abuse coupled with depression, or diabetes coupled with cognitive impairment) make attempting to identify a single cause unfeasible.

- Section 68(2) should be amended to provide RAs with less costly and time-consuming alternatives for action. This section currently requires a Professional Conduct Committee to be convened for relatively minor matters, such as a conviction for some alcohol related offences (eg drunk-driving), when a health review would be a more efficient and effective mechanism for protecting public health and safety.

- Section 69 should also be reviewed to allow for immediate suspension of a practising certificate due to concerns about conduct when there are concerns that the practitioner presents a risk of serious harm. This section currently only allows for a suspension to occur after the practitioner has been "given ... a reasonable opportunity to make written submissions and be heard on the question" and this requirement is being exploited and can result in costly delays that present a risk of serious harm to patients.

- It is submitted that the words “in respect of which that fee is payable” should be deleted from the wording of section 132(6). The way this section is currently worded means that the Council cannot refuse to issue a PC on the basis of an unpaid sum relating to a separate process, such as a competence programme.

- Section 144 requires revision. This section makes removing a practitioner from a register too costly, time-consuming and complex.

- Section 147 should be rewritten so that it also covers doctors who have New Zealand qualifications, but who have had action taken against him or her by an overseas authority.

- Section 174 should include more specific requirements for practitioners who object to providing abortion and contraceptive services. In particular, the requirement that such practitioners "inform [the patient] that he or she can obtain the service from another health practitioner or from a family planning clinic" should require practitioners to assist patients in a timely manner and to refer them to a service that can provide the help they require. The Abortion Supervisory Committee has advised the Council that it is aware of incidents where doctors have delayed providing requested information on abortion services until termination is no longer an option for the patient, and of doctors who have referred the patient to a provider with the same objections and who cannot provide the requested service.

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*Convening a Professional Conduct Committee is accordance with s.71-83 of the HPCAA is an expensive process. A recent and typical example, involving a straight-forward drunk-driving offense where there were no underlying concerns and where the Committee made no recommendations for further action, cost Council $2651.90 – and no doubt also created additional expense for the doctor and health service involved.*