SUBMISSION TO HEALTH WORKFORCE NEW ZEALAND ON THE REVIEW OF THE HEALTH PROFESSIONALS COMPETENCE ASSURANCE ACT

October 2012

Submission to:
Health Workforce New Zealand
National Health Board, Ministry of Health
info@healthworkforce.govt.nz

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1. SUMMARY

This submission represents:

- Consumer
- Academic / research
- Pacific
- Education / training
- Provider
- Non-government organisation
- Professional association
- Other (please specify) – Professional organisation

This submission has been made the College of Nurses Aotearoa (NZ) Inc. and NPNZ as a division of the College.

I do want a copy of the summary of submissions
2. BACKGROUND

This submission represents the joint opinion of The College of Nurses (Aotearoa) NZ Inc (“the College”) and the Nurse Practitioners of New Zealand (NPNZ) as a division of the College. The College is a professional body of New Zealand registered nurses and nurse practitioners from all regions and specialties both within and outside of the District Health Board setting. It provides a voice for the nursing profession and professional commentary on issues that affect nurses, and also the health of the whole community, aiming for excellence in nursing practice and health care delivery which addresses disparities in health.

This submission is the result of previous policy analysis undertaken by the College, internal consultation and direct discussions with College members in a range of leadership positions in different parts of the sector. It also incorporates the results of consultation with additional nursing organisations in New Zealand in order to develop a collective strategic view, including the New Zealand Nurses Organisation (NZNO).

To summarise, the College considers that, overall the HPCA Act has become well established, and is functioning effectively. New Zealand nursing groups are in agreement that the HPCA Act protects public safety, has overseen the implementation of competency reporting frameworks and raised nurses’ awareness of their professional obligations. We do not consider that it would be an efficient use of resources to disrupt the good work that has gone into establishing the HPCA Act systems over the past 10 years.

The HPCA Act does not currently restrict workforce flexibility, however barriers to flexibility have occurred at the bureaucratic level.

The College does not support the establishment of a single regulatory authority for health professionals. However, the College does see some benefit in combining the Nursing Council back room functions with some of the smaller regulatory authorities such as the Chiropractic Board and the Physiotherapy Board (for example), where a well established and efficient Council, such as the Nursing Council, manages the regulatory systems and functions of smaller regulatory authorities.

The College, together with NZNO, sees any political interference in the business and conduct of the regulatory authorities as highly inappropriate.

3. SUBMISSION

3.1 Future focus

3.1.1 How can the HPCA Act improve on achieving the best outcomes for patients through integrated care?

The College considers that there are many other Acts, which require attention in order to reduce barriers to workforce flexibility. We would rather see urgent attention given to these issues.
3.1.2 How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?

The College considers that there is nothing in the current HPCA Act, which restricts workforce flexibility. Workforce flexibility has historically been impeded by bureaucratic procrastination and some degree of medical protectionism. These two issues generally go together. For example, the introduction of the nurse practitioner role in New Zealand has been directly impeded by the persistence of long standing legislative barriers.

3.1.3 How can the HPCA Act promote education and training that has a wider focus, such as effective ways of working in teams, improved communication skills and support for consumers’ self-management?

The College does not consider that the promotion of education and training is the role of the HPCA, but is rather a matter for the individual regulatory authorities and each profession to address.

The principal purpose of the HPCA Act is ‘to protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practice’ (refer Section 3(1)). The Act focuses on one objective – to ensure that individual practitioners do not pose a risk of harm or serious harm to the public. The Act also ensures that individual health practitioners remain accountable for their clinical practice.

3.1.4 Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?

The College considers that there is possibly scope for the HPCA Act to better address the standardisation of these areas. Opportunities exist for common learning across the health professions to occur and regulatory authorities could be required to take the codes of conduct and ethics of other professions into consideration when reviewing their own professional codes.

3.1.5 Do we have the right balance between broad scopes of practice and sufficiently providing information to inform people about what they can expect from a health practitioner?

No comment.

3.1.6 Could / should RAs have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?

This is not a function of the HPCA Act but is rather the role of professional organisations and employers.

3.2 Consumer focus

3.2.1 Does the HPCA Act keep the public safe, involve consumers appropriately in decision-making and assist in keeping the public informed?

The College, together with New Zealand nursing groups, is generally in agreement that the HPCA Act works effectively to protect public safety.
3.2.2 Is information from RAs readily available, particularly as it relates to practitioners and the transparency of complaints and complaint processes? If so, is this information made good use of by the public?

No comment.

3.2.3 Do we have the right balance of laypeople to health professionals on RA boards?

The College believes that due consideration should also be given to ensuring that there is adequate Maori representation on the boards.

3.2.4 Should New Zealand consider introducing consumer forums where the public can communicate with RAs on matters that concern them, as in the UK?

The College would have no objection to this.

3.3 Safety focus

3.3.1 Do we currently make the best use of legislation to keep the public safe from harm when accessing health and disability services?

As previously indicated in section 3.2.1, the College considers that patient safety is effectively protected under current legislation.

3.3.2 Can we make better use of other legislation or employer-based risk management systems and reduce reliance on statutory regulation?

A significant proportion of the regulated workforce is not ‘employed’. There are already systems in place where large employers can have their competency programmes accredited by the relevant regulatory authority, effectively delegating the responsibility to the employer.

3.3.3 What more needs to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?

No comment.

3.3.4 Is the HPCA clear about the level of risk that needs to regulated by statute? If not, what improvements are needed?

No comment.

3.3.5 Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?

The College considers that there should be compulsory professional membership and indemnity insurance. Competency requirements may need definition and be part of the practitioners service agreement with their funder (Ministry of Health for section 88) or the District Health Board or Crown Agent.

3.3.6 In the case of groups of practitioners that might be considered high-risk would it be useful for a risk-profiling approach to be applied by RAs?

No comment.
3.4 Cost effectiveness focus

3.4.1 What role do RAs play in considering the cost impacts of their decisions and the cost benefits of regulations?

Regulatory authorities are required to consult. The Midwifery Council approval of a four-year undergraduate degree and competency requirements had a financial impact that was passed on to students and employers. In this case, the feedback that was provided was not well considered and added a cost where the benefit is unclear and not defined.

3.4.2 Should the HPCA Act define harm or serious harm?

National definitions are already in place and a definition with the HPCA Act would standardise this.

3.4.3 Is the HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve it?

No comment.

3.4.4 Is the right set of regulatory options being applied to manage the risk of harm to the public that different health professions might pose?

No comment.

3.4.5 Could the way RAs administer their functions be improved?

The College is aware that the Government considers that some level of consolidation of regulatory authority function is necessary in order to reduce costs. However, the College does not support the consolidation of RA secretariat functions, which would necessarily result in a reduction of staff members. Registrars of regulatory authorities, together with other RA staff, have significant profession specific knowledge which could be lost if RA functions were to be combined.

The College also does not support the establishment of a single secretariat to manage administrative matters. The Nursing Council is very efficient on all levels and the combination of secretariat functions would necessarily result in the rise in the cost of nursing practicing certificates, which will have major consequences for employers.

3.4.6 Should RAs be required to consult more broadly with relevant stakeholders?

The Nursing Council already consults extensively and broadly with relevant stakeholders and the College would be concerned if this were not occurring elsewhere.

3.4.7 Should the number of regulatory boards be reduced, as in the UK?

The College does not support the establishment of a single regulatory authority for health professionals, nor a reduction in the number of regulatory boards. However, the College can see that, given the huge and well demonstrated efficiency of the Nursing Council, that there may be some value in the Nursing Council combining
with some of the smaller regulatory authorities, such as the Chiropractic Board and the Physiotherapy Board (refer also to our response in section 3.4.5).

3.4.8 What is the ideal size of RA boards?

The College considers that the Nursing Council Board should remain at its current size of seven board members. The Nursing Council manages the largest registrar of practitioners in New Zealand and a reduction in the size of the council will result in an increase in workload pressure for current members.

3.4.9 Additional comments

Employers on the whole have a poor understanding of the regulatory requirements of health professionals. There is very limited training on how the HPCA works. As an example, there are no formal requirements for District Health Board Directors of Nursing in relation to the HPCA Act, even though they are required to apply the legislation. Most Directors of Nursing gain experience of the HPCA Act when they have to refer, or when they are required to appear before a Committee or a Tribunal.

This is also an issue for non-DHB employers. Any changes to the HPCA Act need to address issues of responsibility in relation to the administration of the HPCA Act. Responsibility should not just be limited to the profession and should include professional organisations and employers as well as the public in sharing responsibility.
The RANZCP New Zealand National Committee appreciates the opportunity to comment on the 2012 review of the Health Practitioners Competence and Assurance Act 2003 discussion document.

The RANZCP is the principal organisation representing the medical specialty of psychiatry in New Zealand and Australia and has responsibility for training, examining and awarding the qualification of Fellowship of the RANZCP to medical practitioners.

Currently there are approximately 3500 Fellows of the College who account for around 85 percent of all practicing psychiatrists in Australia and over 50 percent of psychiatrists in New Zealand. New Zealand also has a significant number of Overseas Trained Psychiatrists who are Affiliate members of the College.

The vision of the RANZCP is: A fellowship of psychiatrists leading the achievement of quality psychiatric care and mental health for our community.

The RANZCP New Zealand National Committee would like to highlight that the response time given for this document was short, given the desired level of consultation with College members on such a significant issue. We also note that there was insufficient notice to the sector about the HPCA act regional consultation meetings held in late September.

We wish to note a number of concerns arising from the discussion document, and our response is directed to these concerns rather than being confined to feedback questions. Overall, our key concerns are that the discussion document appears to:

- move away from the core purpose of the HPCA Act, which is to protect the health and safety of the public; and
- lack a clear evidence base regarding how the issues raised arise from the HPCA Act, and how any changes would lead to improvements.

Specific comments on the four sections of the discussion document are noted below.

**FUTURE FOCUS**

While we agree in principle with the comments relating to the need for a sustainable and fit-for-purpose workforce, and better coordinated health and social services (pp 4), it is of concern that the discussion document seeks to include responsibility for workforce development in the HPCA Act. Responsibility for workforce development must sit outside the Medical Council of New Zealand and other Responsible Authorities (RAs). It is the function of RAs to set standards for education, training, accreditation, qualification and ongoing competence of those health practitioners who come under the HPCA Act, thereby working to keep the public safe. To blur this key role with a responsibility for workforce development imposes an additional (and conflicting) accountability that may result in a lowering of standards, thus compromising public safety.
• Integrated care, a flexible workforce and working in teams
The discussion document refers to the integration of primary care with other parts of the health service. However, how this will actually work is still in early stages, and at present is largely unknown. Integration models will need to be developed, and this work is outside the scope of the HPCA Act.

Currently, the HPCA Act framework does not prevent teamwork and workforce flexibility. These are functions that vary across services, often relating to the size and structure of the workforce and the nature of the population(s) served. There are many different styles of teamwork that reflect these differences. Good teamwork depends on the culture of the workplace/service environment and the support of the management/leadership teams. Communication within and between teams is an essential aspect of teamwork and workforce flexibility that needs to be supported at a government level, perhaps via IT infrastructure. ISBAR is an excellent example of a process that aids communication within and between medical professionals.

Integrated care, workforce flexibility and teamwork do need to be supported through policy and infrastructure, but they are not factors that can be successfully legislated on. They are better placed as clear guidelines or recommendations.

The Medical Council of New Zealand provides guidance for doctors on working within teams in the Good Medical Practice document. The RANZCP has also published a number of relevant position statements, including Psychiatrists as team members\(^1\); Relationships between geriatric and psychogeriatric service\(^2\) and; The roles and relationships of psychiatrists and other service providers in mental health services\(^3\).

• Wider focus for education and training — improved communication skills and support for consumer self management
Again, these are factors that may not be effectively regulated by statute, particularly as they encompass not only the skill-set, but how skills are applied: within the team and the doctor-patient relationship. Clinically networked environments need the support of government rather than legislation.

Many organisations already include a wider focus and provide a range of relevant resources for members. For example, the new RANZCP (competency-based) Fellowship Programme for psychiatry training lists competencies that will be gained in the major roles expected of a psychiatrist, which include those of communicator and collaborator\(^4\). In addition the RANZCP has developed a set of online learning modules on chronic condition self management, designed to enhance the understanding and capability of all psychiatrists to better work in collaboration with patients who have chronic mental illness and the patients' families and/or carers\(^5\).

• Standardisation of codes of conduct, ethics and common learning across health professions
Different professional groups with different roles and responsibilities interact with patients/consumers and other professional groups in different ways. Therefore, a ‘one size fits all’

\(^1\) http://www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps47-pdf.aspx
\(^2\) http://www.ranzcp.org/Files/ranzcp-attachments/Resources/College_Statements/Position_Statements/ps31-pdf.aspx
\(^3\) http://www.ranzcp.org/getattachment/Resources/Statements-Guidelines/Position-Statements/47b_PS.pdf.aspx
\(^4\) http://ranzcp.org/Pre-Fellowship/2012-Fellowship-Program/About-the-training-program/Fellowship-competencies.aspx
\(^5\) http://chroniccondition.ranzcp.org/
approach would not work, as standardisation may risk being too loose in relation to some areas and too restrictive in others. Cole’s medical practice in New Zealand clearly sets of the ethical standards and guidelines governing medical practice in New Zealand, and the Medical Council has published a range of standards expected of doctors. The New Zealand Medical Association also has a defined Code of Ethics as do the various professional organisations and employers. RANZCP members are also bound by the RANZCP Code of Conduct, and the RANZCP Code of Ethics.

While establishing common learning across health professions may be of value, it would be better undertaken by an agency such as HWNZ rather than incorporated in legislation.

- **Scopes of practice and provision of information to people about what they can expect from a health practitioner**
  These are two distinct types of information. Scopes of practice have been developed to enable practitioners and providers of service to identify and describe the service being provided and those an individual practitioner is permitted to perform. The information required by the public should have a different approach and level of detail.

- **Mandated RA role in health professional’s pastoral care**
  Pastoral care for health professionals is important, but also presents some difficulties. Under the HPCA Act, RAs must consider public safety first, and as such they have a role to review ‘cases of health practitioners who may be unable to perform the functions required for the practice of the profession’, which may lead to suspension, conditions imposed on, or loss off, practicing certificate or other measures. This makes it unlikely that a practitioner experiencing difficulty is going to seek assistance from an RA, despite the way in which RAs do tend to take a rehabilitative approach. To make pastoral care a mandated role for RAs conflicts with the primary function of protecting public safety.

  There are other options that may provide a solution, such as providing support for an independent (non statutory) group to provide pastoral care and support to practitioners.

**CONSUMER FOCUS**

Many RAs have comprehensive websites that include information specifically for the public on their roles and responsibilities. However, greater efforts could be made centrally by the Ministry of Health and other key agencies to improve health literacy, including knowledge about the HPCA Act and the regulation of health practitioners.

Engagement with, and involvement of, the community is a key priority for the RANZCP. We have a dedicated Community Collaboration Committee comprising consumers and carers from across Australia and New Zealand. The members of this Committee also sit on other RANZCP Boards, Committees, and the governing body (General Council), bringing a community perspective and expertise to all areas of College functions and policy making. We would encourage efforts to increase communication and engagement with the community, but note that this would be enhanced by ensuring the focus remains broad (rather than on specific health issues), and by supporting those involved to communicate with and feed back to their networks.

Currently the balance of lay people to health professionals on RA boards is adequate, but it is important to ensure all those appointed to RA boards have the right mix of skills and experience to perform effectively in such an environment. This could mean that specific training and support is required.
SAFETY FOCUS

There are strong linkages between the HPCA Act and other legislation that safeguards public safety, such as the Health and Disability Commissioner's Act 1994 (and Code of Rights). However, it may be that these linkages could be enhanced though adopting common definitions of key terms where possible. In terms of any gaps in the legislation, we would be interested to hear what gaps HWNZ or the Ministry of Health have identified. It may be more effective for identified gaps to be the topic of specific consultation.

To match the level of risk with the level of regulation, risk must be defined and measured, with any such measures being regularly reviewed to ensure continued effectiveness. Each RA could be required to have a clear definition and measure of risk, but as this will differ across professional groups, it is not practical to provide a single definition.

COST EFFECTIVENESS FOCUS

While cost impacts and benefits should be factored into decision making in so far as possible, the primary role of RAs is to protect public safety. Cost factors are a separate issue from the HPCA Act purpose and functions.

- **Definition of harm/serious harm**
  While definition of these terms may provide a little more clarity and commonality across various legislation, it does risk setting limits and excluding or disadvantaging future events or those whose circumstances may not match the definition.

- **HPCA Act clarity about level of risk**
  The MCNZ definition of risk works well for doctors. It may be most effective for each professional group to have a definition of risk that they are measured against.

- **Regulatory options to manage risk of harm posed by different health professions**
  The regulation of more and more groups under the HPCA Act is one area that does have a clear cost impact and attention could be directed to ensuring that the nature of the perceived risk to public safety is the basis for regulation under the HPCA Act. There are alternative options for regulation of professional groups posing a lower risk that may be less costly than HPCA Act regulation.

- **Improvement of RA functioning**
  Generally, there is always scope to improve and streamline the functioning of organisations. Often this is aligned with factors such as developments in technology and information sharing. However, aspects such as data collection could be standardised across the various RAs, for example many RAs collect information at the time of renewal of practicing certificates but there is a lack of consistency across elements such as that hours that constitute full- or part-time work. Establishing a common data set with information available to the sector could be beneficial.

- **Requirement for RAs to consult more broadly with relevant stakeholders**
  It is the experience of the RANZCP that in general, MCNZ consultation is adequate. A key issue is always timeframes for consultation, as many feedback deadlines do not allow for consultation with organisation memberships, particularly when input from community groups is desired.

- **Reduction in the number of regulatory boards**
  While some of the smaller RAs could potentially be successfully combined to share functions; those governing larger groups of professionals would be better remaining separate.

  There is extensive literature available relating to the optimum size and structure of governing boards, but it is important to note that board members should be appointed on a skills basis and all members should be clear as to the role of the board.
How to have your say

You are invited to submit feedback on the information set out in this document. In particular, it would be helpful to receive your responses to all or any of the specific questions included at the end of each section and gathered together at the end.

You can download and email the submission form to:

info@healthworkforce.govt.nz

or post your submission to:

HPCA Submissions
Health Workforce New Zealand
National Health Board, Ministry of Health
PO Box 5013
WELLINGTON 6145

You can also download this document and other information including dates and venues for the regional public meetings from http://h pcaactreview.hiirc.org.nz.

The closing date for submissions is Friday 26 October 2012.
Submitter’s details
You do not have to answer all the questions or provide personal information if you do not want to.

This submission was completed by: Richard Townley

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Organisation (if applicable): Pharmaceutical Society of New Zealand Ltd

Position (if applicable): CEO

Are you submitting this as:
(Tick one box only in this section)

□ on behalf of a group or organisation(s)

Please indicate which sector(s) your submission represents
(You may tick as many boxes as apply)

□ Education/training

□ Professional association

All submissions will be acknowledged by the Ministry of Health and a summary of submissions will be sent to all those who request a copy. The summary will include the names of all those who made a submission, unless individuals request that their names not be published.

Do you wish to receive a copy of the summary of submissions?

□ Yes

Your submission may be requested under the Official Information Act 1982. If this happens, the Ministry of Health will release your submission to the person who requested it. However, if you are an individual as opposed to an organisation, the Ministry will remove your personal details from the submission if you check the following box:

□ I do not give permission for my personal details to be released under the Official Information Act 1982.

□ I do not give permission for my name to be listed in the published summary of submissions.
Questions

Future focus

1. We want to achieve the best outcomes for patients through integrated care, and so health professional regulation needs to keep pace with how integration improves care and service models. How can the HPCA Act improve this?

Comment:

2. How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?

Comment:

By supporting the movement of medicines management tasks along the professional task bar to better utilise the capability and capacity of the underutilised pharmacist workforce.

The government has signalled that no new professions will be registered under the Act. However the Pharmaceutical Society would like to see an ability for our own Pharmacy Council (and other RAs as appropriate) to register subgroups of support staff as required by the profession.

The Society seeks to allow some pharmacy technicians working at a higher scope of practice (to be defined) to become registered practitioners which would allow the ability to set competence standards and an appropriate level of regulation. This defined group of technicians would then be allowed to function with greater independence – freeing up pharmacists time to move more into medicines management tasks and function at the top of their scope.

Funding arrangements now exist that allow pharmacists to move from being funded primarily for a dispensing/distribution role to more of a medicines management role. However they are restricted in their ability to do so because of the requirement for ‘direct personal supervision’ of technicians dispensing of prescription medicines required under Regulation 42 of the Medicines Regulations 1984. While an amendment to this regulation could remove the requirement for direct personal supervision, the risks associated with this activity by a health care provider would need to be addressed in the HPCA Act.

This would not necessarily apply to all pharmacy technicians, at least initially.
3. How can the HPCA Act promote education and training that has a wider focus, such as effective ways of working in teams, improved communication skills and support for consumers’ self-management?

Comment:

The discussion document notes in reference to balancing the costs and benefits of regulation how “DHBs bear the costs of continuing education requirements (through employment agreements)”. We wish to highlight that the majority of the pharmacy profession is not employed by DHBs and receive no support in this mandatory requirement for continuing education (CE) and continuing professional development (CPD). Even those pharmacists who are employed within DHBs receive inconsistent and often extremely limited support for their CE. Therefore the costs associated with meeting this regulatory requirement is mostly being transferred to the profession and individual practitioners.

This presents a significant direct cost to pharmacists in order to meet their education and professional development requirements.

4. Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?

☐ Yes

Comment:

The RAs appear to have little ability to enforce Codes of Ethics or act on potential or actual breaches, unless there is a significant risk of patient harm. Codes of Ethics should form a professional standard of practice and when ‘a pattern or practice over a period of time’ suggests the required standard is not being met (as used in the Medical Council working definition of risk of harm) this is not necessarily being acted on unless patient safety is at risk.

The Society would like to see a greater ability for RAs to act on deficient professional standards that have not yet reached a threshold for disciplinary processes associated with breaches of the law or competence.

5. Do we have the right balance between broad scopes of practice and sufficient providing information to inform people about what they can expect from a health practitioner?

☐ Yes

Comment:
6. Could/should RAs have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?

☐ Yes
☐ No
☐ Not sure

Comment:

RAs should not have a directly mandated role in health professional’s pastoral care. This is the responsibility of professional bodies not a regulator, as pastoral care needs to be separated from disciplinary functions. However RAs could have a more defined role in directing practitioners towards pastoral care, particularly when patterns of practice may not have breached competence standards or Codes of Ethics, but a significant risk of this occurring may be present.

Currently any mentors or counsellors appointed by an RA report to that RA who can then decide to proceed to disciplinary steps as often “more evidence” has been “collected” by the mentor. The appointment of a mentor is best directed via an accredited professional body who can then report on progress (or otherwise) towards identified competence (or other) goals. Specific evidence collection remains between practitioner and mentor, but appropriate documentation standards are now being met (or not) are provided to the RA.

There needs to be a system available by which practitioners that are performing below standard, but without a specific harmful incident occurring to be flagged and directed towards mentoring. This would be triggered at a lower threshold than current mechanisms for directing practitioners to undergo oversight due to competence issues.

Consumer focus

7. Does the HPCA Act keep the public safe, involve consumers appropriately in decision-making and assist in keeping the public informed?

☐ Yes
☐ No
☐ Not sure

Comment:

More could be done.
As mentioned above, sometimes the RA is restricted in what they can do when a health professional is of concern.

The Act provides little ability for an RA to ‘manage’ a practitioner working at an unacceptable practice level unless they break the law or have health or other concerns that impact on competence. Some practitioners are identified as working within the law and or within competence levels, but persistent activities that potentially put the safety of consumers at risk. Acknowledging the question of risk definition.
8. Is information from RAs readily available, particularly as it relates to practitioners and the transparency of complaints and complaint processes? If so, is this information made good use of by the public?

☐ No

Comment:

Registers
Pharmacists are reliant on public registers of practitioners for all the RAs responsible for prescribing scopes of practice. It is a legal and safety function of pharmacists dispensing from prescriptions to identify prescribers and in some cases confirm their scope and legitimacy for prescribing.

Section 149 of The Act requires RAs to publish registers "in any form it thinks fit" and "in printed or electronic form".

149 Authorities to publish register
(1) Each authority must from time to time publish the register that it keeps, in any form it thinks fit.
(2) A publication under subsection (1) may include address information about a health practitioner who has not objected to the authority in writing to the inclusion of that information, or who has withdrawn a previous objection to that inclusion.
(3) Publication may be in printed or electronic form.
(4) The authority may publish the register with some of the information it contains abbreviated, so long as all abbreviations are explained or easily understandable by members of the public.
(5) Subsections (2) and (3) do not limit the generality of subsection (1).

The Pharmaceutical Society would like to see more stringent requirements for RAs to make available this information electronically and to update this on a more frequent basis than currently occurs – particularly the Medical Council register online. It is unreasonable to expect enquiring members of the public and practicing pharmacists checking prescription legalities to only have up to date information available by telephone during the hours that the office of an RA is open. Pharmacies by their nature are not limited to 9 to 5 office hours of standard work days but will often be open extended hours in weekends and over public holidays. We see this as an important function of the scope of pharmacists to guard public safety with respect to the provision of prescription medicines.

Complaints
Complaints processes need to be more streamlined as they are not currently achieving “quick and cost-effective resolution for all parties involved” as stated in the discussion document. The HPCA Act has slowed this process since inception and costs have increased.

Complaints are dealt with very slowly causing extreme stress on the health practitioner as they appear to be judged ‘guilty until you can prove you are innocent’. Some who go to HPDT are dealt with very lightly – suspended for short periods, when they should be struck off the register. We feel that perhaps lay people are more lenient than the health practitioners on the panel as they perhaps do not fully appreciate the professional expectations of the profession.
It is often taking far too long to get to a HPDT hearing and this lessens the case when a health practitioner has sometimes been practising for years since the offence in question.

The HPCA Act in 2004 said that it would speed up disciplinary actions – and has in fact slowed down the process.

Complaints to HDC are dealt with there and then forwarded to the RA for any professional issues – almost like being tried twice.

Any ACC treatment injury gets a ‘triple whammy’ by the Ministry of Health/ACC, RA and sometimes HDC as well, all viewing documents and making judgement.

9. Do we have the right balance of laypeople to health professionals on RA boards?
   ☐ Yes
   ☐ No
   Comment:

10. Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?
    ☐ No
    Comment:

Safety focus

11. Do we currently make the best use of legislation to keep the public safe from harm when accessing health and disability services?
    ☐ Yes
    ☐ No
    ☐ Not sure
    Comment:

12. Can we make better use of other legislation or employer-based risk management systems and reduce reliance on statutory regulation?
    ☐ Yes
    ☐ No
13. What more needs to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?

Comment:

The provider of an accredited recertification programme is involved with directly managing practitioners and assisting with their CPD requirements to get them to the required standard. This provider is in a position to ensure that the practitioner will meet the standard by audit.

If this function is recognised and audit 'by exception' is carried out by the provider of the competence programme – the costs of that could be transferred from the RA to the accredited provider.

If practitioners meet the requirements of the accredited recertification programme, then they should be exempted from audit as sufficient evidence is being provided.

14. Is the HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?

Comment:

Sole practitioners have a greater need for support to participate in education and professional development as they do not receive the same direct collegial relationship and 'mentoring' from working alongside a peer.

Sole practitioner pharmacists have an even greater need for allowing defined pharmacy technicians to dispense without the requirement for “direct personal supervision” as mentioned above. This frees the pharmacist time from the technical aspects of dispensing (clinical aspects do remain).
16. In the case of groups of practitioners that might be considered high risk, would it be useful for a risk-profiling approach to be applied by RAs?

☐ Not sure

Comment:

Cost effectiveness focus

17. What role do RAs play in considering the cost impacts of their decisions and the cost benefits of regulation?

Comment:

The RA has an obligation to be fiscally responsible.

The RAs role is governance not management of the profession however these lines are often blurred.

The power given to an RA as an authority has to be carefully managed as consultations appear to be exercises in communication with little effect to change things. The more regulations usually means more barriers resulting in more costs and costs are usually bureaucratic.

The HPCA Act is now nearly 10 years old so the culture of competence is now embedded in the pharmacy profession. There should therefore be less regulation needed to ‘enforce’ this compared with the beginning of the Act. An RAs job is to ensure competence and to discipline those outside.

The Pharmacy Council uses their authority to instruct the professional bodies to perform functions and carry out competence tasks. There is a danger when these tasks for recertification and competence – which are applicable to all registered pharmacists – become more details, more complicated and hence more costly.

RAs have a compulsion to create competition it seems due to pressure from other government areas of influence that they should not be seen to favour one particular provider. However NZ is a relatively small country and with around 3000 pharmacists practicing, there is only just enough to be viable for one professional body to provide professional programmes (recertification/competence). Other areas of government do not seem to have the same problem with single providers eg. Pharmac.

Pharmacy has a competency framework that aligns with the profession and funders of services.

The burden of cost is increasing and the Society supports any review of to make regulatory processes more efficient whilst still keeping the pharmacy identity.
18. Should the HPCA Act define harm or serious harm?

- Yes
- No
- Not sure

Comment:
The definition of harm should be left to clinicians in consideration to relevant legislation and codes (eg. ACC Act). The example provided of the Medical Council is very helpful in that it identifies and compares patterns or practice over a period of time against one off events and performance.

19. Is HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?

- No

Comment:

20. Is the right set of regulatory options being applied to manage the risk of harm to the public that different health professions might pose?

- Yes
- No
- Not sure

Comment:

21. Could the way RAs administer their functions be improved?

- Yes

Comment:
22. Should RAs be required to consult more broadly with relevant stakeholders?
   □ Yes
   Comment:

   Not more broadly but more in depth! RAs are required to consult with relevant stakeholders, yet many consultations are a foregone conclusion – and are a ‘Clayton’s consultation’.

23. Should the number of regulatory boards be reduced, as in the UK?
   □ Yes
   □ No
   □ Not sure
   Comment:

   If the function of the RAs is predominantly to administer bureaucratic rules, then fewer boards are necessary. The Society has supported the need for our own specific Pharmacy Council as pharmacy is different to other professions and needs to be treated differently.
   [have training schemes, have contracts]

24. What is the ideal size of RA boards?
   Comment:
25. Are there other issues you would like to raise?

Comment:

Regarding comparisons made against Australia made in the discussion document:

The Society notes the importance of being cognisant of relevant activities in Australia, but that these are not necessarily worth replicating.

Through the Pharmacy Council of New Zealand, the profession is now accountable to the Australian Pharmacy Council and we are concerned about how this sits with the regulations set by the NZ government.

Standards in Australia are set according to economies of scale which do not necessarily provide value or meet the needs of NZ practitioners. For example, the intern training programme for graduates entering the pharmacy profession, a number of pharmacy bodies in Australia provide this online with limited face to face training and limited pastoral care – because of the economic advantages when training a large number of candidates over a vast area. This does not provide the same level of competence-orientated training and pastoral care that NZ’s programme provides with training days and personal contact and personalised pastoral care with every candidate.

NZs emphasis on competence is far greater than that in Australia who are currently mostly still looking at education and CPD as their evidence of competence.
How to have your say

You are invited to submit feedback on the information set out in this document. In particular, it would be helpful to receive your responses to all or any of the specific questions included at the end of each section and gathered together at the end.

You can download and email the submission form to:

info@healthworkforce.govt.nz

or post your submission to:

   HPCA Submissions
   Health Workforce New Zealand
   National Health Board, Ministry of Health
   PO Box 5013
   WELLINGTON 6145

You can also download this document and other information including dates and venues for the regional public meetings from http://hpcaactreview.hiirc.org.nz.

The closing date for submissions is Friday 26 October 2012.
Submitter’s details

You do not have to answer all the questions or provide personal information if you do not want to.

This submission was completed by: Dr Margot Skinner

Address: P O Box 56
	Dunedin 9054

Email: Margot.skinner@otago.ac.nz

Organisation (if applicable): School of Physiotherapy University of Otago

Position (if applicable): Acting Dean

Are you submitting this as:
(Tick one box only in this section)
☐ an individual (not on behalf of an organisation)
☒ on behalf of a group or organisation(s)
☐ other (please specify): ............................................................................................................

Please indicate which sector(s) your submission represents
(You may tick as many boxes as apply)

☐ Consumer ❏ Family/whānau
☐ Academic/research ☐ Māori
☐ Pacific ☐ District health board
☒ Education/training ☐ Local government
☐ Provider ☐ Funder
☐ Non-government organisation ☐ Prevention/promotion
☐ Professional association ☐ Other (please specify): ...............................................................

All submissions will be acknowledged by the Ministry of Health and a summary of submissions will be sent to all those who request a copy. The summary will include the names of all those who made a submission, unless individuals request that their names not be published.

Do you wish to receive a copy of the summary of submissions?
☒ Yes
☐ No
Your submission may be requested under the Official Information Act 1982. If this happens, the Ministry of Health will release your submission to the person who requested it. However, if you are an individual as opposed to an organisation, the Ministry will remove your personal details from the submission if you check the following box:

- [ ] I do not give permission for my personal details to be released under the Official Information Act 1982.
- [ ] I do not give permission for my name to be listed in the published summary of submissions.

Questions

Future focus

1. We want to achieve the best outcomes for patients through integrated care, and so health professional regulation needs to keep pace with how integration improves care and service models. How can the HPCA Act improve this?

Comment:

Ensure that key health professions remain regulated with broad non prescriptive terms that enable the Act to be interpreted in light of a dynamic health environment.

2. How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?

Comment:

The scopes of practice must remain broad and non prescriptive but with distinct protection of title. Most of what is needed for the Act to be relevant for a flexible workforce is would be developed through regulation and gazetted notice rather than through a change in the legislation itself.

3. How can the HPCA Act promote education and training that has a wider focus, such as effective ways of working in teams, improved communication skills and support for consumers’ self-management?
These components should be developed through the process of competence and interpretation of scopes of practice rather than through legislative change. Already as demands for health care and the health environment itself change professions such as physiotherapy are able to adapt through a dynamic interpretation of competence and associated guidelines – this is not restricted by the legislation.

The potential for e.g. limited prescribing rights to be broadened to include other health professions can also be regulated and controlled without the need to legislative change.

4. Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?

☐ Yes
☐ No
☐ Not sure

Comment:

A number of these initiatives can and are being addressed at the pre-entry level through the education programmes – the programmes need to adapt to meet best practice requirements and to educate students who are going to be the health workforce of the future. A collaborative approach rather than one which is legislated is likely to have more flexibility – the key context of any change in practice is always with the patient’s best interests in mind. The Discipline Tribunal is an example of a process which works well and shares many standards and expectations as well as having the chair and lay representatives in common.

5. Do we have the right balance between broad scopes of practice and sufficient providing information to inform people about what they can expect from a health practitioner?

☐ Yes
☐ No
☐ Not sure

Comment:
With increased use if the internet by the general public and increased amounts of information being made available by regulatory authorities through this route we suggest that the balance is already at the right level.

6. Could/should RAs have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?
   - [ ] Yes
   - [ ] No
   - [ ] Not sure

Comment:

Pastoral care is a professional responsibility rather than a primary role of the RAs. Guidelines for continuing professional development are dynamic and develop over time. This is best included in guidelines for continuing professional development rather than being a mandated role for the RA.

Consumer focus

7. Does the HPCA Act keep the public safe, involve consumers appropriately in decision-making and assist in keeping the public informed?
   - [x] Yes
   - [ ] No
   - [ ] Not sure

Comment:

The HPCA and New Zealand in general has been a leader in including the public in decision making and in providing the public with a direct say in processes through the inclusion of lay people on governance boards and in the Discipline Tribunal.

8. Is information from RAs readily available, particularly as it relates to practitioners and the transparency of complaints and complaint processes? If so, is this information made good use of by the public?
   - [x] Yes
   - [ ] No
   - [ ] Not sure

Comment:
Outcomes of complaints are available for the public to access; the RAs are required to report through the Minister to Parliament and the RAs publish regular news letters that can be accessed by the public. Consumer groups are able to make submissions and would be advocating for greater transparency if it were an issue.

9. Do we have the right balance of laypeople to health professionals on RA boards?

☐ √ Yes
☐ No
☐ Not sure

Comment:

Yes there is a good balance – Boards can vary in size but the proportion of lay membership is appropriate as is the case for their membership of other groups such as the Discipline Tribunal.

10. Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?

☐ Yes
☐ No
☐ √ Not sure

Comment:

New Zealand does not have to follow the British model and there is no reason in the current environment why an RA could not instigate a consumer forum if there were a need; consumers are able to comment on reviews of e.g. relating to review of competencies etc. The unique ACC legislation also enables the public to be relieved from having to be party to a litigious process and so may well reduce the need for the public to use a system of consumer forums.

Safety focus

11. Do we currently make the best use of legislation to keep the public safe from harm when accessing health and disability services?

☐ √ Yes
☐ No
☐ Not sure

Comment:
There may be room for some streamlining but the process in general appears to be robust.

12. Can we make better use of other legislation or employer-based risk management systems and reduce reliance on statutory regulation?

- [ ] Yes
- [ ] No
- [ ] Not sure

Comment:
In New Zealand a large number of health professionals e.g. physiotherapists work in small practices and are self employed and so do not have the luxury of employer based risk management systems. The concept of reducing reliance on statute is a good one but one system does not fit all and therefore the HPCA is useful to ensure all practitioners have the same requirements. However in process that are part of the RA’s responsibility under the Act such as accreditation of programmes run by health education providers some processes that may be covered through the institutes own good practices/quality assurance processes may not need to be replicated.

13. What more needs to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?

Comment:
The processes for enquiry into a health professional’s standard of practice can be drawn out both for the practitioner and complainant. Some streamlining in this area is worth considering.

14. Is the HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?

- [ ] Yes
- [ ] No
- [ ] Not sure
15. Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?

Comment:

The professional bodies have guidelines in place as well as the RA’s ethics that are relevant to all registered practitioners in any profession; ongoing monitoring of competence through self review and guidelines that are already in place is the preferred way to ensure that standards of practice are maintained.

16. In the case of groups of practitioners that might be considered high risk, would it be useful for a risk-profiling approach to be applied by RAs?

☐ □ □ □

Yes
No
Not sure

Comment:

The best way is to work with the profession to reduce the risk and at the same time ensure that the public are aware of the risk. Additional measures should be in place for accountability of those working in high risk areas within a profession.

Cost effectiveness focus

17. What role do RAs play in considering the cost impacts of their decisions and the cost benefits of regulation?

Comment:
Regulation remains one of the best ways to assure the public of their safety. RAs are already accountable through their reporting requirements and thus RAs already have a key role in considering cost impacts.

18. Should the HPCA Act define harm or serious harm?
   - Yes
   - No
   - Not sure
   [ ] Not sure
   Comment:
   
   It is already defined in ACC legislation and so this is one area where cross over of legislation can be considered as the definition should be the same.

19. Is HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?
   - Yes
   - No
   - Not sure
   [ ] Not sure
   Comment:
   
   This is already clear.

20. Is the right set of regulatory options being applied to manage the risk of harm to the public that different health professions might pose?
   - Yes
   - No
   - Not sure
   [ ] Not sure
Comment:

Yes it is important to have a degree of flexibility – the standard and fairness is maintained through the commonalities shared by the Discipline Tribunals.

21. Could the way RAs administer their functions be improved?

☐ Yes
☐ No
☐ Not sure

Comment:

Sharing of databases is useful but a degree of autonomy is also healthy.

22. Should RAs be required to consult more broadly with relevant stakeholders?

☐ Yes
☒ No
☐ Not sure

Comment:

In our experience this is already well done.

23. Should the number of regulatory boards be reduced, as in the UK?

☐ Yes
☐ No
☒ Not sure

Comment:
No the sharing of the legislation is the important component although health dialogue to determine more commonality in e.g. accreditation processes, definition of terms etc is helpful rather than reducing the number of functioning boards.

24. What is the ideal size of RA boards?
Comment:

The size of the profession may determine the availability of membership but 9 is a good working size, still enabling robust discussion and a quorum if some members are unavailable; many tasks can be delegated to subcommittees for workload distribution.

25. Are there other issues you would like to raise?
Comment:
31 October 2012

Health Workforce New Zealand
National Health Board,
Ministry of Health
PO Box 5013
Wellington 6145

Attention: Brenda Wraight

Email: info@healthworkforce.govt.nz

2012 Review of the Health Practitioners Competence Assurance Act 2003

The Human Rights Commission (the Commission) welcomes the opportunity to make a submission on the review. The Commission has an interest in the legislation for the following reasons:

- it has responsibility for monitoring and reporting on New Zealand’s compliance with international human rights standards;
- it is designated as one of three independent organisations with responsibility to monitor and report on the implementation of the United Nations Convention on the Rights of Persons with Disability (the Disability Convention); and
- it administers a complaints mechanism that includes complaints about discrimination which can involve complaints about the provision of health services.

Despite this the Commission recognises that many of the questions in the review do not fall within its expertise, so it has limited its comments to the section on consumer focus, taking into account New Zealand’s commitments under the Disability Convention and the human rights framework as it applies to the development of policy and legislation.

Q.7: Does the Act keep the public safe, involve consumers appropriately in decision-making and assist in keeping the public informed?

Although the Commission is not in a position to say whether the Act keeps the public safe, the current framework is undoubtedly an improvement on the paternalistic decision making of the past. We consider, however, that greater involvement of consumers in decision making would further enhance accountability.

A human rights approach emphasises the international human rights norms, promotes the participation of those most directly affected, along with accountability, empowerment and non-discrimination and balancing the human rights of all those involved, favouring the most vulnerable where there is a conflict.

Greater consumer involvement in decision making would be compatible with a human rights approach as it would both empower consumers and increase transparency. It would also be consistent with the principle of full and effective participation of persons with disabilities in the Disability Convention1 and the New Zealand Disability Strategy2.

1 Art.3 UNCRPD
While the Commission does not receive many complaints by people with disabilities about being excluded from decision making, we do get complaints on the effect of decisions made about them and it is increasingly obvious that people with disabilities expect engagement with policy initiatives that affect them.

There is also some evidence that consumer participation can lead to improvements in health services³ - presumably because people with direct experience of disability or certain health conditions have a better understanding of what their service needs are.

The Commission therefore considers that further thought could be given to involving consumers, particularly those with disabilities, in decision making to a greater extent.

Q.8: Is information from RAs readily available, particularly as it relates to practitioners and the transparency of complaints and complaints processes? If so, is this information made good use of by the public?

All complaints made to statutory registration bodies must be referred to the Health and Disability Commissioner, but people can also complain to the Commission about alleged discrimination in the provision of health services.

While we are clearly not in a position to comment on the availability of information about regulatory bodies, one of the functions of the Commission under Part 3 of the Human Rights Act is providing information as a way of resolving complaints of discrimination⁴. Over the last two years the Commission has received approximately 1800 complaints relating to health professionals, treatment or access to services. The majority of these were referred on to other agencies. This suggests to the Commission that the public is not adequately informed about what processes are available and/or how to go about accessing them.

The Commission feels it is important to reinforce that information should be readily available and accessible to people with disabilities. One of the obligations under the Disability Convention is to ensure that people with disabilities have the right to (inter alia) receive information on an equal basis with others⁵. This involves providing information in accessible formats and technologies appropriate to different kinds of disabilities in a timely manner and without additional cost.

The Commission also considers it is important for consumers to be able to understand the reasoning underlying decisions made about them which may be a reason for allowing greater access (whether by way of review or some other mechanism) to RA decisions.

Q.9: Do we have the right balance of laypeople to professionals on RA boards?

² New Zealand Disability Strategy: making a world of difference /whakanui oranga. Ministry of Health (2001) Objective 5 of the NZDS has as its objective the encouragement of disabled people taking part in decision-making as service users, as staff in the delivery of services, and in the governance, management, planning and evaluation within all services that disabled people access.
⁴ The Commission has the option of not pursuing a complaint if an alternative complaints mechanism exists.
⁵ Art.5(a) UNCRPD
While we recognise that the criteria for inclusion of lay people includes knowledge and experience of matters likely to come before the Boards or Tribunal, the focus appears to be mainly on health issues.

Disability raises issues that are distinct from health or illness. Under article 25 of the Disability Convention, people with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. This requires States like New Zealand that have ratified the Convention to ensure that people with disabilities are not disadvantaged in the quality of health services needed specifically because of their disabilities. The Commission considers therefore that expertise on disability should be explicitly recognised in the criteria for membership of the RA boards and that it may mean increasing the number of lay people making up the pool of those available and sitting on boards.

Q.10: Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?

The Commission considers that consumer forums to facilitate engagement of the public with regulatory authorities would be a good idea as it would lead to greater openness and transparency and greater confidence in health services. Such forums would provide an opportunity for service users to interact with the regulatory bodies allowing consumers to be involved in improving the quality of services and RAs to learn from the experiences of consumers.

Consumer forums would also be a way of overcoming the fragmented approach to consumer involvement in health services that currently exists. As Coney has observed6 New Zealand lacks a strong consumer voice and there is no organised system of networking or sharing information within the sector. Given that there are already a number of consumer groups organised around certain populations – for example, the Mental Health Consumers Network and Disabled Persons Assembly - it should not be too difficult to establish a health consumer forum.

I hope this is some help and look forward to the next phase of the process. Should you have any further questions please contact Sylvia Bell, Principal Legal & Policy Analyst, DD 09 306 2650.

Yours sincerely

Paul Gibson
Disability Rights Commissioner

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6 Supra fn 2 at 2
How to have your say

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WELLINGTON 6145

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The closing date for submissions is Friday 26 October 2012.
Submitter’s details

You do not have to answer all the questions or provide personal information if you do not want to.

This submission was completed by: Julie Robinson (with BOPDHB senior nurses & midwives)

Address: Private Bag 12024

Email: Julie.robinson@bopdhb.govt.nz

Organisation (if applicable): Bay of Plenty District Health Board

Position (if applicable): Director of Nursing

Are you submitting this as:
(Tick one box only in this section)

☐ an individual (not on behalf of an organisation)
X ☐ on behalf of a group or organisation(s)
☐ other (please specify)...........................................................................................................

Please indicate which sector(s) your submission represents
(You may tick as many boxes as apply)

☐ Consumer ☐ Family/whānau
☐ Academic/research ☐ Māori
☐ Pacific X ☐ District health board
☐ Education/training ☐ Local government
☐ Provider ☐ Funder
☐ Non-government organisation ☐ Prevention/promotion
☐ Professional association ☐ Other (please specify): ..............................................................

All submissions will be acknowledged by the Ministry of Health and a summary of submissions will be sent to all those who request a copy. The summary will include the names of all those who made a submission, unless individuals request that their names not be published. A copy of all submissions received will be forwarded to the Gambling Commission to assist its independent consultation process.

Do you wish to receive a copy of the summary of submissions?

☑ Yes
☐ No
Questions

Future focus

1. We want to achieve the best outcomes for patients through integrated care, and so health professional regulation needs to keep pace with how integration improves care and service models. How can the HPCA Act improve this?

Comment:

The current HPCA Act would not appear to restrict integrated care or new service delivery models. The current Act serves to protect public safety while providing some flexibility. Within the RN scope of practice, for example, the Nursing Council has kept this very broad to enable workforce flexibility. Integrated care is about professionals working in an interdisciplinary way rather than being determined by an Act. The HPCA Act could continue to monitor the RA’s and the scopes of practice that sit under each of the RA’s.

2. How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?

Comment:

Blurring of the boundaries of scopes of practice remains an issue but we are unclear as to how the Act might address this aspect. This also needs to be weighed up against the danger of an RA being so prescriptive in describing a scope of practice that there is complete inflexibility.

Barriers to workforce flexibility tend to come from professional patch protection rather than the Act per se.

Criteria or guidelines related to emerging roles and the unregulated workforce may be useful to determine inclusion or exclusion from coverage under the Act.
3. How can the HPCA Act promote education and training that has a wider focus, such as effective ways of working in teams, improved communication skills and support for consumers’ self-management?

- Yes
- No
- Not sure

Comment:

It could ensure that this was included in the competencies for all the professionals covered by the Act. The responsibility should however remain with the employer and the professions to ensure education is appropriate and the RAs to ensure educational providers are meeting standards.

Nursing and midwifery competencies currently have a focus on teamwork, consumer education and communication.

4. Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?

- Yes
- No
- Not sure

Comment:

There the potential for this although it will need to be a commitment from all the RAs.

5. Do we have the right balance between broad scopes of practice and sufficient providing information to inform people about what they can expect from a health practitioner?

- Yes
- No
- Not sure

Comment:

Nursing supports broad scopes of practice which are necessary for patient centred care. The Code of health and Disability Consumer’s Rights provides principles upon which the professions, the RA and the individual practitioner can all provide information for consumers.
6. Could/should RAs have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?

☐ Yes
✓ No
☐ Not sure

Comment:
The RAs are required to follow the processes under the Act. Involvement in pastoral care could lead to a blurring of the boundaries and a potential conflict of interest with the requirement to protect public safety. This is the role of the professional associations, union, employers and other support personnel.

Consumer focus

7. Does the HPCA Act keep the public safe, involve consumers appropriately in decision-making and assist in keeping the public informed?

✓ Yes
☐ No
☐ Not sure

Comment:
The current Act provides a high degree of public assurance for safety. Complaints mechanisms are well known for example through HDC. Both nursing and midwifery supports consumer involvement some of which is already mandated under the Act.

8. Is information from RAs readily available, particularly as it relates to practitioners and the transparency of complaints and complaint processes? If so, is this information made good use of by the public?

☐ Yes
✓ No
☐ Not sure

Comment:
Some RA’s do it well. RAs should ensure the process is publicly available with online registers containing any findings. The H & D Commissioner refers to the RA’s when necessary.

A balance between the public’s right to transparency and a fair process for the individual until the finding is made needs to be preserved.

9. Do we have the right balance of laypeople to health professionals on RA boards?
   - Yes
   - No
   - Not sure

Comment:

We need to ensure the balance is kept between lay people and the professionals. Nursing Council has 3 lay people and 6 professionals. It is important to maintain the breadth of nursing perspective given the broad nursing contribution to health. Lay people are important in maintaining public safety and provide a consumer perspective.

10. Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?
    - Yes
    - No
    - Not sure

Comment:

This is a good idea but what evaluation has been completed regarding the cost and effectiveness of these in the UK? Undoubtedly this cost would be added to the APC cost. Consumers need to be informed and knowledgeable to participate in this process.

Safety focus

11. Do we currently make the best use of legislation to keep the public safe from harm when accessing health and disability services?
    - Yes
    - No
    - Not sure

Comment:
We believe the current Act along with others protects public safety.

12. Can we make better use of other legislation or employer-based risk management systems and reduce reliance on statutory regulation?
   ☐ Yes
   √ No
   ☐ Not sure
   Comment:
   Many smaller employers may not have well developed risk management systems or resources in place. Any employer based system would need to be consistently applied.

13. What more needs to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?
   Comment:
   Overall we do not see the current legislation requires significant change.

14. Is the HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?
   ☐ Yes
   ☐ No
   √ Not sure
   Comment:
Perhaps there is benefit in the RAs who oversee small number of practitioners joining together.

15. Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?
Comment:
Both the RA’s and the professional groups have a responsibility to manage risk by ensuring the practitioner maintains competency / or recertification programmes that involve peer review of their practice. Tele/video links could be used for professional support.

16. In the case of groups of practitioners that might be considered high risk, would it be useful for a risk-profiling approach to be applied by RAs?

☐ Yes
☐ No
√ Not sure
Comment:

Cost effectiveness focus

17. What role do RAs play in considering the cost impacts of their decisions and the cost benefits of regulation?
Comment:
This is reflected in the cost of their APC’s and costs recovered from approval of education programmes and auditing.

18. Should the HPCA Act define harm or serious harm?
   - ☐ Yes
   - ☑ No
   - ☐ Not sure
   Comment:
   Definitions are very difficult to get exactly right. Usually leads to a requirement for more guidelines to explain the definition.

19. Is HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?
   - ☐ Yes
   - ☐ No
   - ☑ Not sure
   Comment:
   Nursing Council has engaged with employers on what is appropriate for the employer, Council, individual and professional organisations to manage. The balance would appear about right.

20. Is the right set of regulatory options being applied to manage the risk of harm to the public that different health professions might pose?
   - ☑ Yes
   - ☐ No
   - ☐ Not sure
Comment:

Only commenting in relation to nursing and midwifery.

21. Could the way RAs administer their functions be improved?

- Yes
- No
- Not sure

Comment:

RAs like any organisation can always improve systems and processes. From a nursing perspective the Council has made a range of improvements such as on line APCs. We are not able to comment on other RA's.

Communication can always be improved.

22. Should RAs be required to consult more broadly with relevant stakeholders?

- Yes
- No
- Not sure

Comment:

Wide consultation already occurs.

23. Should the number of regulatory boards be reduced, as in the UK?

- Yes
- No
- Not sure

Comment:
Nursing and midwifery do not support the one RA model.
Efficiencies could be gained by sharing back office functions particularly for smaller RAs.

24. What is the ideal size of RA boards?
Comment:

Needs to be relevant to the total membership one size does not fit all. However cost needs to be kept in mind balanced with the need for good representation from lay and professional members. It would be hard to see how less than 8 could function.

25. Are there other issues you would like to raise?
Comment:
How to have your say

You are invited to submit feedback on the information set out in this document. In particular, it would be helpful to receive your responses to all or any of the specific questions included at the end of each section and gathered together at the end.

You can download and email the submission form to:

info@healthworkforce.govt.nz

or post your submission to:

HPCA Submissions
Health Workforce New Zealand
National Health Board, Ministry of Health
PO Box 5013
WELLINGTON 6145

You can also download this document and other information including dates and venues for the regional public meetings from http://hpcactreview.hiirc.org.nz.

The closing date for submissions is Friday 26 October 2012.
Submitter’s details

You do not have to answer all the questions or provide personal information if you do not want to.

This submission was completed by:  
(name)  
Terry Moore and Rosaleen Robertson

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Southern Cross Hospitals Limited

Position (if applicable):  
CEO  
Chief Clinical Safety and Quality Officer

Are you submitting this as:  
(Tick one box only in this section)

☐ an individual (not on behalf of an organisation)  
☒ on behalf of a group or organisation(s)  
☐ other (please specify)...........................................................................................................

Please indicate which sector(s) your submission represents  
(You may tick as many boxes as apply)

☐ Consumer  
☐ Academic/research  
☐ Pacific  
☐ Education/training  
☐ Provider  
☒ Non-government organisation  
☐ Professional association  
☐ Family/whānau  
☐ Māori  
☐ District health board  
☐ Local government  
☐ Funder  
☐ Prevention/promotion  
☐ Other (please specify):  
...........................................................................................................

All submissions will be acknowledged by the Ministry of Health and a summary of submissions will be sent to all those who request a copy. The summary will include the names of all those who made a submission, unless individuals request that their names not be published.

Do you wish to receive a copy of the summary of submissions?  

☒ Yes  
☐ No
Your submission may be requested under the Official Information Act 1982. If this happens, the Ministry of Health will release your submission to the person who requested it. However, if you are an individual as opposed to an organisation, the Ministry will remove your personal details from the submission if you check the following box:

☐ I do not give permission for my personal details to be released under the Official Information Act 1982.

☐ I do not give permission for my name to be listed in the published summary of submissions.

Questions

Future focus

1. We want to achieve the best outcomes for patients through integrated care, and so health professional regulation needs to keep pace with how integration improves care and service models. How can the HPCA Act improve this?

Comment:

By being enabling

2. How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?

Comment:

Perhaps in the way RHPs are educated; could a stair-cased approach from school to post graduate levels be enabling to different levels of RHP registration?

The length and comprehensiveness (complexity) of some programmes could be a barrier to attracting and growing a workforce.
3. How can the HPCA Act promote education and training that has a wider focus, such as effective ways of working in teams, improved communication skills and support for consumers’ self-management?

- Yes
- No
- Not sure

Comment:

Maybe through core competencies across all RHP professions, e.g.:
- Communication skills
- Team work and collegiality
- Concordance attitudes and skills

4. Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?

- Yes
- No
- Not sure

Comment:

Standardisation of codes and ethics
If there is to be a single RA then a single simple code of conduct and ethics would be appropriate.
However for distinct professions and RHPs who have a greater balance of power, or where there is a greater level of proven risk to consumers, would naturally retain their more detailed codes and ethics.

Common learning and therefore practises is a moral imperative
- Hand Hygiene
- Safety Checklists
- Communication skills
- Team work and collegiality
- Concordance attitudes and skills
- etc
5. Do we have the right balance between broad scopes of practice and sufficient providing information to inform people about what they can expect from a health practitioner?

☑ Yes
☒ No
☒ Not sure

Comment:

Yes in some situations, yes but they are not well linked for consumers or employers to access.

No in other situations, where having restriction like ‘gingival margins’ is restrictive to some RHP performing skill-based tasks to meet evolving technological or procedural needs and could add system cost or delays.

6. Could/should RAs have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?

☑ Yes
☐ No
☐ Not sure

Comment:

Support “RAs could provide better care for health professionals to support their health, competence and welfare in order to prevent the escalation of complaints and the resulting costs to the system and the public. This is particularly the case where health practitioners are self-employed or working in sole practice, but RAs could also work in partnership with employers, organisations, colleagues and colleges where relevant.”

Suggest addition of organisations and colleagues to above.

A national programme for assessment and monitoring across all RHPs and RA/s would help protect the safety of consumers and be invaluable for individual RHPs (or organisations) that may have a need, requirement or desire to measure and monitor their physical-physiological and or psycho-social state. RHPs who have diseases, injuries, idiosyncrasies and the natural but uneven effects of ageing should be able to be tested to ensure RHPs are fit-for-practice.
**Consumer focus**

7. Does the HPCA Act keep the public safe, involve consumers appropriately in decision-making and assist in keeping the public informed?

☐ Yes
☐ No
☐ Not sure

Comment:

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8. Is information from RAs readily available, particularly as it relates to practitioners and the transparency of complaints and complaint processes? If so, is this information made good use of by the public?

☐ Yes
☒ No
☐ Not sure

Comment:

Suggest the following barriers:

- variation in the ways and detail of what RAs record which relates to individual RHP information; and
- consumer competency to undertake web-based searching skills to check for information.

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9. Do we have the right balance of laypeople to health professionals on RA boards?

☐ Yes
☐ No
☐ Not sure

Comment:
10. Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?

☐ Yes
☐ No
☐ Not sure

Comment:

The RA could create portals for individual and group communication.

Safety focus

11. Do we currently make the best use of legislation to keep the public safe from harm when accessing health and disability services?

☐ Yes
☒ No
☐ Not sure

Comment:

A significant gap relates to Section 35 of the HPCAA. Section 35 needs to be expanded to include additional organisations and or individuals. Please comments 13 below.

12. Can we make better use of other legislation or employer-based risk management systems and reduce reliance on statutory regulation?

☐ Yes
☐ No
☒ Not sure

Comment:

Employer or organisations’ systems robustness will vary. Duplication of systems is costly just as legislation can be if is overly and impractically detailed.
13. What more needs to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?

Comment:

A significant gap relates to Section 35 of the HPCAA.

Section 35 needs to be expanded to include additional organisations and or individuals.

We have had extensive correspondence with the Medical Council of New Zealand, including the Health and Disability Commission and the Director General of Health on this matter.

Having a limited list of organisations named (S. 35) means consumers and organisations are at significant risk where there is a serious safety issue which has led to an RHP having rights to practice terminated or limited and where an organisation is not notified.

Currently there is no obligation on RAs to report widely to all places of practice (places of ‘work’) or colleagues; discovery of an issue is left to chance (or establishment of a special notification arrangement with higher risk RAs) and or random checking of RHP public registers.

Renewal application for APC should include a requirement to list all places of work/ practice and include individual colleagues who may be in a collaborative practice, facility or network.

14. Is the HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?

☐ Yes
☐ No
☐ Not sure

Comment:
15. Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?

Comment:

Strengthen the RA processes for:

- ascertaining the quality and appropriateness of activities for maintaining competency to practice and
- measuring, assessing and monitoring capability (see 6 above); this could at the instigation of the RA or the RHP.

16. In the case of groups of practitioners that might be considered high risk, would it be useful for a risk-profiling approach to be applied by RAs?

☑ Yes
☐ No
☐ Not sure

Comment:

This could be effective:

- some medical colleges currently have valuable definitions of the levels of practice; and
- for new RAs and new disciplines/professions/RHPs who are providing non-traditional or alternative healthcare, definitely, e.g. other countries have east west practitioners

Cost effectiveness focus

17. What role do RAs play in considering the cost impacts of their decisions and the cost benefits of regulation?

Comment:
18. Should the HPCA Act define harm or serious harm?

☒ Yes
☐ No
☐ Not sure

Comment:

The Medical council of New Zealand has clear definitions of the:

- Risk of harm
- Risk of serious harm.

These have proved helpful in management and decision-making.

19. Is HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?

☐ Yes
☐ No
☒ Not sure

Comment:

Defining levels of risk (e.g.

known risk, such as highly complex medical modalities, or higher risk of extreme complications or outcomes such as in obstetrics or

unknown risk, where a modality is new, lacks an evidence base, or of another culture)
20. Is the right set of regulatory options being applied to manage the risk of harm to the public that different health professions might pose?

☐ Yes
☐ No
☒ Not sure

Comment:

There are ‘health’ and ‘healthcare’ providers who currently do not have an RA.

If the process for a discipline that provides a healthcare service to consumers was more inclusive (less restrictive) could this increase consumer safety and quality and reduce cost? For example it is only recently that anaesthetic technicians have come under an RA.

There are presumably individuals/disciplines providing healthcare for whom being, under an RA regime, could lead to consumer and economic benefits.

Where there are services and businesses (and a jeopardy to provision of quality consumer care) which are under threat due to workforce shortages, could entry to that sector be made more attractive if that workforce was under the auspices of an RA, and therefore deemed a professional discipline (see reference to stair-casing in section 2 above)?

21. Could the way RAs administer their functions be improved?

☐ Yes
☐ No
☒ Not sure

Comment:

At times the ones we deal with are very quick and responsive.

Sometimes processes seem slow (where there is an issue of individual competence or due to bottlenecks such as renewal of APCs).
22. Should RAs be required to consult more broadly with relevant stakeholders?
   □ Yes
   □ No
   □ Not sure
   Comment:

23. Should the number of regulatory boards be reduced, as in the UK?
   □ Yes
   □ No
   □ Not sure
   Comment:

24. What is the ideal size of RA boards?
   Comment:
25. Are there other issues you would like to raise?

Comment:

To confirm we are supportive of:

- Strengthening consumer protection in areas of proven risk

- Standardising and streamlining legislation and the design of institution/s only if this is more effective and reduces costs (costs are largely passed onto organisations though reimbursement of APC fees, costs are incurred where RA processes are inefficient or ineffective)

- Improving performance of RAs including having:
  - greater clarity in relation to responsibilities for managing difficult situations which spans performance and behaviour
  - credible, reasonable and reliable processes for appropriate maintenance of safety to practice.
New Zealand Branch

HPCA Submissions
Health Workforce New Zealand
National Health Board, Ministry of Health
PO Box 5013
Wellington 6145

2012 Review of the Health Practitioners Competence Assurance Act 2003

The Royal Australian and New Zealand College of Radiologists (RANZCR or the College) is the professional body responsible for the determination and maintenance of standards and the training and education of diagnostic radiologists and radiation oncologists in Australia and New Zealand. The RANZCR’s interest in this matter relates to the quality of the service provided by its members and the best health outcomes for patients.

The College would comment at this time that the 2012 Review of the Health Practitioners Competence Assurance Act 2003 discussion document appears to have little or no evidence or examples relating to the perceived concerns with the current regulatory model, or what benefits could be achieved by any proposed changes. The College accepts that the Act should be reviewed on a regular basis, but would caution on change for change sake without sound evidence to prove the need for that change.

The College supports the submission made by the Council of Medical Colleges in New Zealand however it wishes to formally record its concern at the short time frame available to consult meaningfully with the RANZCR New Zealand membership and respond in any detail to this document.

Additional time and wider consultation is warranted before any further discussion regarding change in policy or the HPCA Act is considered.

Dr Michael Baker
New Zealand Chair

26 October 2012
30 October 2012

HPCA Act Submissions
Health Workforce New Zealand
National Health Board
Ministry of Health
PO Box 5013
WELLINGTON 6145

Dear Sir/Madam

2012 Review of the Health Practitioners Competence Assurance Act 2003

Thank you for inviting my comments on the Ministry of Health’s 2012 review of the Health Practitioners Competence Assurance Act 2003 (HPCA Act).

In preparing my comments, I have referred to submissions my Office has made in relation to past reviews of the HPCA Act. I enclose those submissions for your reference, and endorse the comments contained therein.

Introductory comments

HDC Role
As you are no doubt aware, my role as Health and Disability Commissioner is to promote and protect the rights of health and disability services consumers, as set out in the Code of Health and Disability Services Consumers’ Rights (the Code). The Code sets out the rights of health and disability services consumers and the corresponding obligations on the providers of those services. The duties in the Code apply to registered and unregistered health and disability service providers.

One of my functions under the Health and Disability Commissioner Act 1994 is to make public statements about any matter affecting the rights of health and disability consumers. In my view, the review of the HPCA Act is a matter that affects such rights.

HDC Vision
During my time as Health and Disability Commissioner, I have been sending a clear message to the sector of my vision for health and disability services in New Zealand. That vision is a consumer-centered system; a system built on the concepts of seamless service, patient engagement, transparency, and an empowering culture. Accordingly, I support steps to strengthen the HPCA Act in accordance with the principles of care integration, safety and the central role of the consumer; all principles that the Ministry has used to guide its review.
Support for HPCA Act
At the outset, I note that I strongly support a robust regulatory system for the regulation of health practitioners in New Zealand. The HPCA Act is fundamental legislation in terms of protecting the safety of health and disability consumers by ensuring that health practitioners are competent and fit to practise. There are, however, some key areas in which I consider further improvements could be made, and I discuss these below. I have arranged my comments in accordance with the four principles the Ministry has used to guide its review.

Future focus
Integration of care
The Ministry is seeking to achieve the best outcomes for patients through integrated care, and has asked how the HPCA Act can improve health professional regulation to keep pace with this.

I agree with the Ministry that care integration is an important factor in quality service provision, and that quality and safety are becoming increasingly dependent on how multidisciplinary teams and clinical networks operate. Failure or inadequacy in care integration is a recurring theme in complaints to my Office, which often result in consumers receiving a poor standard of care. As I pointed out in a recently published opinion,¹ in any healthcare system, there are a series of layers of protections and people, which together operate to deliver seamless service to a consumer. When any one or more of these layers do not operate optimally, poor outcomes result and consumers are at risk of being harmed.

The Ministry has noted in the consultation document that the HPCA Act focuses on the competence and accountability of individual clinicians in teamwork situations. However, the Ministry also considers that a complementary focus across health professions is necessary to address common sources of error and inefficiency involved in professional communication and collaboration. I agree. The question is whether this is a matter that can be addressed by the HPCA Act and, if so, how.

In the current regulatory framework, the importance of care integration is recognised in Right 4(5) of the Code, which gives consumers a right to cooperation among providers to ensure quality and continuity of services. This applies to cooperation both intra- and inter-professionally, across multi-disciplinary teams. In my view, communication and cooperation between providers, comprehensive documentation, and the involvement of the consumer are key to successful care integration. I encourage health practitioners to ask questions and raise concerns with each other, including across disciplines, and all administrators and staff (registered and unregistered) to maintain a culture that both allows and encourages such interactions.

Accordingly, the Code currently imposes a responsibility on both registered and unregistered service providers to cooperate with each other to ensure quality and continuity of services. The HPCA Act could potentially improve health professional regulation to further support integrated care by promoting standardised competencies in the areas pertinent to successful care integration.

¹ Opinion 09HDC01883, 15 June 2012.
In respect of standardised competencies, I note that the principal purpose of the HPCA Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions. However, there is no definition of “competence” or “fitness to practise” in the HPCA Act. Section 16 refers to “fitness for registration”, and there is a requirement under section 16(1)(a) that a registrant must be able to “communicate effectively for the purposes of practising within the scope of practice in respect of which the applicant seeks to be … registered”. However, this section has limited value in respect of promoting care integration as a core competency. While some responsible authorities have comprehensive documents setting out basic professional competencies, for example, the Midwifery Council of New Zealand and the Nursing Council of New Zealand, others do not.

The review of the HPCA Act provides an opportunity to consider the value of prescribing core competencies for all health professions, to support care integration. This could be by way of an amendment to the HPCA Act to prescribe that each responsible authority must issue a statement of basic competencies, which would include, for example, the core competencies of effective communication and cooperation between providers, promoting consumer engagement and self-management, and comprehensive documentation. These are issues frequently raised in complaints to my Office regardless of a health practitioner’s profession, and in my view, are core competencies that all health practitioners should demonstrate if they are competent and fit to practise in their profession.

_HPCA Act promotion of education and training_

The Ministry asks how the HPCA Act can promote education and training that has a wider focus, such as effective ways of working in teams, improved communication skills, and support for consumer self-management.

Part 3 of the HPCA Act provides mechanisms for ensuring the competence of “a” health practitioner, and is activated only where a concern has arisen. The current provisions relating to the education of practitioners concern only the education programmes for qualification, and do not specifically address ongoing education or professional development. While generally all responsible authorities recognise the central role of continuing professional development, there is potential for the HPCA Act to require health practitioners to engage in continuing education and training to maintain their competence and fitness to practise.

It is important that training programmes across all responsible authorities equip health professionals with the necessary skills and knowledge to ensure they provide services of an appropriate standard. This includes ensuring health practitioners are aware of their obligations under legal, ethical and professional standards, including the Code. While the training needs of health practitioners will differ across the professions, there are some training areas common to all professions (including in relation to the core competencies discussed above). In those areas, the HPCA Act could require the responsible authorities to ensure that frequent courses are available and require that ongoing education and training, including in the areas of core competencies, be a prerequisite to registration and re-registration by the responsible authority.
While each profession will have its own specific education and training requirements, I support responsible authorities sharing information and resources for education and training in areas where there is overlap. In addition to education and training in core competencies, this may include, for example, education and training on learning from complaints, on the management of high risk health professionals, on international developments in health, and on administrative efficiency.

Pastoral care
The discussion document asks whether responsible authorities should have a mandated role in the pastoral care of their registrants. In my view, the health and fitness to practise provisions under sections 45 to 51 of the HPCA Act are sufficient. The professional associations, such as the New Zealand Medical Association, the New Zealand Nursing Organisation, and the College of Midwives also offer practitioners professional support.

Consumer focus
As noted in my introductory comments, my vision for the sector is a consumer-centred system, which involves sharing information and understanding, engagement between provider and consumer, quality and continuity of care, a supportive and transparent environment – all of which are underpinned by respect for the consumer and their values and preferences, and the role of the consumer’s family.

However, the HPCA Act should be careful not to place a disproportionate responsibility on the consumer. Ultimately, protection of consumers is not achieved through a statute, but relies on those organisations and individuals who are responsible for educating, training and reviewing health practitioners. There is also individual responsibility that lies with the health practitioners themselves.

Competence reviews
The discussion document asks whether the HPCA Act keeps the public safe. I consider that some improvement could be made in the area of competence reviews by responsible authorities. In my view, the HPCA Act should provide a lower threshold for competence reviews, and allow for responsible authorities to take more prompt action on competence concerns, in the same way that they are able to when health concerns are raised about a practitioner. Under section 39 of the HPCA Act, authorities can only order an interim suspension of, or impose interim conditions on, a health practitioner’s practising certificate if there is a “risk of serious harm”. In order to keep consumers safe from potentially harmful practitioners, I suggest that the threshold in section 39 be lowered to simply “a risk of harm”.

Information sharing
The discussion document asks questions about the adequacy of the transparency of information and processes to the public, particularly as it relates to complaints and complaint processes.

There is a discrepancy between the public’s ability to access information held by my Office and that held by responsible authorities. My Office is subject to the Official Information Act 1982 (OIA), and handles regular requests for information from both the public and the parties to complaints. However, responsible authorities are not
subject to the OIA. This results in an inconsistency between the transparency of the HDC and responsible authorities' complaints processes.

If I refer a complaint to a responsible authority under section 34(1)(a) of the Health and Disability Commissioner Act 1994, and the responsible authority undertakes a review of the practitioner's competence, the consumer will often not be provided with information about the outcome of the responsible authority's consideration of their complaint or the outcome of any review undertaken in response to the complaint. In these cases, a consumer will often ask my Office for information about the outcome of the review. Clearly, details about the outcome of a responsible authority's consideration of a complaint or of a competence review is information that is more closely connected with the functions of a responsible authority. It would therefore be desirable for my Office to be able to transfer such requests for information to the responsible authority under section 14 of the OIA. However, under the current scheme, my Office is obliged to give access to that information, unless one of the withholding grounds under the OIA applies. Ideally, in the interests of transparency and consumer engagement, the same principles of availability of information about complaints should apply to both HDC and responsible authorities.

Consumer input
The discussion document asks whether to introduce consumer forums, so that the public can communicate with responsible authorities on matters that concern them. In my view, this would be an excellent development. An increase in the number of consumers involved in responsible authorities' processes, and on Boards, should also be considered.

HDC's Consumer Advisory Group advises my Office on:

- the handling of consumer complaints about health and disability services;
- how to improve the quality of health and disability services;
- public interest issues where HDC can take a lead;
- policy issues raised by the Commissioner; and
- promotion and education.

The Consumer Advisory Group also provides advice to the Medical Council of New Zealand on matters concerning the Council's functions. In my experience, the voice of consumers is an indispensable means of improving both service provision and mechanisms for complaints resolution.

Safety focus
Regulation under the HPCA Act
The HPCA Act's role in preventing harm to the public is complemented by my Office's functions. While the HPCA Act only governs registered health practitioners, I have jurisdiction to consider complaints about any person holding themselves out as providing health services to the public.\(^2\) In reality, complaints about unregistered providers constitute a very small portion of the total complaints to my Office,\(^3\) but my

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\(^2\) Health and Disability Commissioner Act 1994, section 3(k).

\(^3\) In the 2011/2012 financial year, fewer than 3% of total complaints received by HDC were about unregistered providers.
ability to address the practice of unregistered providers is effective in closing some of the "gaps" presented by the registration scheme under the HPCA Act.

There are differences in the remedies available to consumers, depending on whether a provider is registered. Currently, if a provider breaches the Code, I can refer that provider to the Director of Proceedings (the DP). If a provider is registered, proceedings can be brought in either the Health Practitioners Disciplinary Tribunal (the HPDT) or the Human Rights Review Tribunal (the HRRT), or both. If a provider is unregistered, proceedings can only be brought in the Human Rights Review Tribunal (HRRT).

The HRRT can award compensatory damages for losses suffered and/or lost benefits (although typically awards are for injury to feelings, humiliation and/or loss of dignity) and the HRRT has the power under section 57(1)(d) of the Health and Disability Commissioner Act to award punitive damages if there has been a flagrant disregard of a consumer's rights. The HPDT does not have similar powers to award damages. In a small number of cases for matters that do not constitute a treatment injury, it may be necessary and/or appropriate for the Director of Proceedings to institute proceedings in the HPDT to hold a practitioner professionally accountable for a breach of the Code, as well as to seek damages for a consumer through the HRRT (for example, in cases concerning a breach of sexual boundaries). In these circumstances, it would be helpful if the HPDT could also award damages that would otherwise only be available in the HRRT. This would ensure a more efficient process, effective use of resources, and would reduce consumer and provider stress in needing to be involved in two separate proceedings.

The discussion document asks whether we can make better use of employer-based risk management systems and reduce reliance on statutory regulation. I support employers having a role in ensuring that their staff are competent and remain fit to practise, for example, through supporting continuing professional development and responding promptly when an employee's practice raises questions about his or her competence. However, it is arguable that there is an inherent conflict of interest in employer-based regulation, and for professions that carry a significant risk of harm, the role of the employer should not take the place of an external regulatory authority. The role of the employer can also be complicated in the case of practitioners who practise in several locations and between the public and private sector. In the previous Commissioner's Tauranga Hospital Inquiry, concerns were raised about the competence of a surgeon who worked at three hospitals – one public and two private. While two of the hospitals had taken steps to address concerns about his competence (including restricting his practice), the failure to share information with other hospitals (in part because of privacy concerns) meant that there was no coordinated response to the risk he posed to the public, and he continued to practise unrestricted at the third hospital. In that case, the employer response was insufficient to protect the public from the potential risk posed by that surgeon.

The discussion document asks for suggestions for how practitioners in sole practice can better manage risks related to their clinical practice. I note that it may also be appropriate for those in sole practice to be required to belong to a peer group and attend monthly "supervision" meetings.
Risk of harm
The discussion document asks whether the level of risk that needs to be regulated by statute is clear. Sections 34 and 35 of the HPCA Act require HDC and responsible authorities to promptly notify one another if there is reason to believe that a health practitioner may pose a risk of harm to the public. I note that the use of the word “may” means that there does not need to be proof of actual harm, which is helpful in terms of the requirement that notification must be “prompt”.

“Harm” is not defined in the HPCA Act and I consider that the HPCA Act would benefit from clarifying what is intended by the use of that term. Without limiting the considerations which may be relevant to the assessment of “harm”, in assessing such matters, my Office generally considers that a risk of harm may be indicated by:

- a pattern of practice over a period of time that suggests a practitioner may not meet the required standard of competence or conduct;
- a single incident that demonstrates a significant departure from accepted standards of practice;
- recognised poor performance where local interventions have failed;
- criminal offending; or
- professional isolation with declining standards becoming apparent.

This guidance is similar to that used by the Medical Council of New Zealand. In my view, the criteria used by every responsible authority should be clearly aligned.

Other areas for clarification
I note the comments in previous submissions by this Office in relation to some areas of uncertainty in the HPCA Act.

Conclusion
Overall, the HPCA Act is essential in protecting the health and safety of members of the public by ensuring that health practitioners are competent and fit to practise their professions. The HPCA Act, and the current review, has the opportunity to be instrumental in bringing about the kind of culture change that is necessary for health and disability services to become truly consumer-centred.

I am happy to elaborate further on my comments above, if that would be helpful. Otherwise, I look forward to hearing from the Ministry regarding the next step in the review process.

Yours sincerely

[Signature]

Anthony Hill
Health and Disability Commissioner

Enc   Submission dated 19 February 2009
      Submission dated 20 December 2007
      Submission dated 21 May 2007
Dear Debbie

Review of the Health Practitioners Competence Assurance Act 2003 — Report to the Minister of Health

Thank you for the opportunity to comment on the recommendations of the report on the Review of the Health Practitioners Competence Assurance Act 2003 (the HPCA). Overall, I agree with the proposed recommendations of the final draft of the review report. I agree that the new complaints process with its close links to the Health and Disability Commissioner appear to be working well. There are, however, some key areas in which further improvement could be made. I refer to this Office’s previous submissions dated 21 May and 20 December 2007. In relation to the recommendations, I have the following specific comments:

**Recommendation 7: Collaboration among responsible authorities**
I strongly agree that responsible authorities should collaborate with the Ministry of Health and Australian authorities to develop risk-based standards, process and assessment models to be used for assisting overseas-trained practitioners. As noted in the report on page 10, the Health and Disability Commissioner’s report on Dr Roman Hasil identified a number of areas for improvement in terms of registration processes.

**Recommendation 10: Elections to responsible authorities**
I note that recommendation 10 provides that section 120(4) of the HPCA remains unchanged and the question whether to allow elections should continue to be considered on a case-by-case basis. As noted in the report the Health and Disability Commissioner did not support elections (submission dated 21 May 2007). However, if case-by-case decisions are to continue, it is questionable whether there should be different approaches for different professionals.

**Complaints and disciplinary matters**
As noted above I agree that the complaints system is working well. In my view the responsible authorities have a clear role in relation to complaints about the appropriateness of a practitioner’s conduct. I agree that section 70 does not prohibit an authority from dealing with a complaint in the professional disciplinary context after it has been closed by the Commissioner.
Recommendation 22: Interim suspensions
I strongly support recommendation 22 which allows a responsible authority to delegate its functions to its Registrar to assist to expedite matters which affect patient safety. It is critical that authorities are able to take prompt action where there is a risk of serious harm to the public.

Recommendation 25: Health Practitioners Disciplinary Tribunal
I strongly support recommendation 25 which would allow the Tribunal to notify any employer of orders of the Tribunal if the Tribunal is satisfied that such disclosure is in the public interest.

Chapter 8: Protected quality assurance
I am pleased that you have noted a consumer’s right to open disclosure of adverse advents and the concern that patients are being excluded from discussions about events involving them because they are part of a protected quality assurance activity. You have identified the tensions in relation to protection and openness and acknowledged the ongoing related work in this area, in particular the incident management system. It is critical that the protections provided are not used as a way of preventing proper disclosure of information in other contexts, or to prevent due process under other processes.

I agree with recommendation 31, which supports research into the value and use of protected quality assurance activities. I also support the simplification of the reporting requirements. It is disappointing to note that the information currently being reported is not valuable and that the Ministry has been unable to disseminate any learnings from it.

Part 3: Competence, fitness to practise and quality assurance — Recommendation 37
I support recommendation 37 which provides that section 49 is amended to allow a responsible authority to require an examination by an appropriate health practitioner.

As noted in the previous submission, improvements need to be made to the process when there is a poorly performing practitioner to ensure patient safety is paramount. The Health and Disability Commissioner strongly supports consideration being given to enabling registration authorities to take swift action on competence concerns in the same way they are able to when health concerns are raised about a practitioner.

I trust that these comments are of assistance and I look forward to receiving a copy of the final report.

Yours sincerely

Nicola Sladden
Chief Legal Advisor
20 December 2007

Ryan McLean
Sector Policy Directorate
Ministry of Health
P O Box 5013
WELLINGTON

Dear Ryan

Review of the Health Practitioners Competence Assurance Act 2003

Thank you for the opportunity to be involved in identifying issues to be considered during the Ministry’s review of the Health Practitioners Competence Assurance Act 2003 (the HPCA).

Under section 14(1)(d) of the Health and Disability Commissioner Act 1994 one of the Commissioner’s functions is to make public statements in relation to any matter affecting the rights of health and disability consumers. Clearly the HPCA is one of the legislative cornerstones in terms of protecting the safety of health and disability consumers by ensuring that health practitioners are competent and fit to practise. Overall HDC considers that the HPCA has been a welcome development. There are however some key areas in which further improvement could be made.

Key issues

Information sharing
In HDC’s view, improvements need to be made to the notification requirements where there is a poorly performing practitioner. At present there is an anomaly in relation to practitioners who are not ‘employees’. Furthermore, the threshold for such notifications should be reconsidered along with the provisions relating to information sharing.

Currently sections 34 and 35 of the HPCA only cover employees and not practitioners with admitting rights or access agreements. Accordingly a private hospital has no obligation to notify the registration authority that it has withdrawn visiting privileges of a health practitioner for reasons related to competence. Similar issues could arise in relation to maternity facilities which have access agreements with independent midwives or doctors.

Once a registration authority has reason to believe that a health practitioner may pose a risk of harm to the public, section 35(1) requires that it must notify the practitioner’s employer. However this obligation does not clearly extend to notifying other facilities where a health practitioner may practise on the basis of a relationship other than employment. Rather, section 35(2) only provides that notice may be given to any person who works in partnership or association with the practitioner. I understand that
some registration authorities do in fact routinely notify facilities such as private hospitals in such situations, however it is clearly preferable to have this as an express requirement rather than a discretion.

These gaps were highlighted in the Commissioner’s Tauranga Hospitals Inquiry (a copy of this report is enclosed). This inquiry related to a surgeon who worked at three hospitals – one public hospital and two private hospitals. While two of the hospitals had taken steps to address concerns about the surgeon’s competence (including restricting his practice) the failure to share information (with other hospitals or the Medical Council) meant that there was no coordinated response and that he continued to practise unrestricted at the third hospital. The inquiry showed that there are strong public safety reasons for reconsidering these aspects of section 34 and 35.

Competence reviews
The review of the HPCA could be enhanced by providing further information regarding the operation of certain provisions. One such area is competence reviews. It is HDC’s perception that competence reviews are taking longer than desirable and in many instances getting bogged down in legal challenges. It would be disappointing if this was the case, given the confidential and rehabilitative nature of the reviews and the important part they play in ensuring that practitioners are competent. Also, there are clear public safety issues if the process becomes drawn out and prompt action is not taken on competence concerns. From the information published by registration authorities, it is difficult to get an accurate picture as to how this process is operating.

In HDC’s view, consideration should be given to reviewing these provisions in the HPCA to better enable registration authorities to take prompt action on competence concerns in the same way that they are able to when health concerns are raised about a practitioner. Obviously the process needs to be fair and include procedural safeguards for practitioners. However HDC is concerned that at present these factors are outweighing public safety factors. For example, interim suspension can only occur under section 39 if there is a “risk of serious harm to the public” and after the practitioner has been informed and given the opportunity to be heard. In contrast, more immediate action can be taken if there are health concerns – although it would seem that competence issues pose no less of a public safety issue than a practitioner with health problems. HDC also considers that consideration should be given to lowering the threshold in section 39 to a “risk of harm” rather than a “risk of serious harm”.

Consideration should also be given to the threshold for notification set out in section 34. Section 36(4)(a) allows registration authorities to review competence if there is reason to believe that a practitioner’s competence may be deficient. Given the confidential and rehabilitative nature of competence reviews, HDC considers that this lower threshold should also be adopted in section 34.

Director of Proceedings
There seems to be something of a legislative lacuna in relation to the Director of Proceedings giving notice under section 34(2). Section 34(2) obliges the Director of Proceedings to notify the registration authority if she believes that a practitioner may pose a risk of harm to the public by practising below the required standard of competence. Obviously the Director of Proceedings is only likely to form this view
when a matter is referred to her i.e., after the conclusion of an investigation by HDC. However, section 69 limits a registration authority’s ability to order interim suspension to instances where an investigation by HDC “is pending.” We suggest that the wording of section 69 should be reconsidered because as currently drafted it seems to undermine the efficacy of section 34(2) in relation to notifications by the Director of Proceedings.

Set out below are further comments on other areas in the HPCA which we consider should be revisited.

Enforcement of the Act
You have asked for comments on the Ministry’s approach to enforcing the HPCA. In my view the Ministry’s approach to enforcement could be further clarified. While the Ministry states that it has the role of investigating alleged breaches of the HPCA, it is HDC’s observation that there appears to be some confusion as to whether it is the registration authorities or the Ministry which should enforce sections 7, 8 and 9 of the HPCA.

For example a complaint made to this Office regarding a registered nurse performing a restricted activity (surgical/operative procedure) was brought to the attention of the Ministry. However the Ministry took that view that as the matter involved a nurse, it should be viewed as an issue under section 8 of the HPCA rather than section 9. It was also the Ministry’s view that it was the registration authority which should take action in this situation on the basis that it was a disciplinary matter. While I can appreciate the reason for taking this approach to that complaint, it seems that there should be some clarification as to respective responsibilities of the Ministry and registration authorities. I have seen the guidelines produced by the Ministry relating to enforcement, and the respective roles are not canvassed in this document either.

Competence and recertification
It would be our observation that there seems to be a blurring of recertification processes and competence processes. We have also observed instances where practitioners are routinely recertified despite significant health and/or performance concerns. The answer to addressing these concerns may lie more in the implementation and interpretation of the HPCA rather than the drafting itself. Nonetheless they are important issues to consider.

As mentioned above, it is difficult to comment on the efficacy of certain notification provisions (refer to questions 17 and 20 in the consultation document) given the lack of data about how often they are being used. Anecdotally HDC has seen examples of these provisions operating both well and poorly.

Protected quality assurance activities
Under the Code of Health and Disability Services Consumers’ Rights, health and disability consumers in New Zealand have a right to open disclosure of any adverse events in their health care. HDC is concerned that wide use of protected quality assurance activities conflicts with this right. This concern is strengthened by reports from patients of being excluded from discussions and investigations as part of a protected quality assurance activity regarding adverse events that happened to them.
This area is another where further information would be useful to enable assessment of the operation of this part of the HPCA. I agree that protected quality assurance activities have a useful place, however anecdotal evidence suggests that they are possibly used too widely and sometimes inappropriately. Indeed we have heard medical defence lawyers advocating the use of protected quality assurance activities wherever possible so as to avoid making internal investigations public. Furthermore there appears to be a lack of data or evidence as to whether such activities are actually leading to improvements in patient safety.

Further information about the approval process would be useful along with the numbers of applications made, those approved and those declined. Before conferring protection, the Minister must be satisfied that doing so is in the public interest. We would be interested in further detail about how the public interest is assessed. From the Ministry publication it appears that this decision is based on information provided by the practitioners/applicants.

Professional conduct committees
The figures set out in appendix 5 of the discussion document indicate that there is a significantly different approach taken to discipline by different registration authorities. On the face of it these figures suggest a lack of consistency between authorities and it would be interesting to explore the reasons for this difference.

Health Practitioners Disciplinary Tribunal (HPDT)
I have sought the views of the Director of Proceedings regarding those parts of the HPCA that relate to disciplinary proceedings and have incorporated her comments in this submission.

HDC considers that having a single tribunal for all regulated professions has been beneficial and led to consistency in decisions and process. However the HPDT needs an adequately resourced secretariat, which it does not have at present.

In terms of the membership of the HPDT, it is HDC’s view that, as is currently the case, the chair (and deputy chairs) should have litigation experience and that the lay members should not generally be lawyers.

It would be useful for the HPDT to have the capacity to deal with multi-practitioner/team based matters. We consider that developing this capacity would enable more effective consideration of cases where more than one practitioner is involved in a patient’s care. It would also avoid situations where individuals have different hearings where each argues that the responsibility or culpability lies with the other practitioner. In our view this capacity would not be difficult to organise although some legislative amendment would clearly be required. Obviously developing this capacity would not entail members of one profession being involved in decisions relating to a member of another profession.

Appeals
At present a practitioner’s rights of appeal (section 106(2)) are different to those of the Director of Proceedings under section 106(3). It is HDC’s view that consideration should be given to giving practitioners should have the same rights of appeal as the
Director of Proceedings. Such an amendment would avoid practitioners resorting to judicial review proceedings due to the absence of a right of appeal.

I trust that these comments are of assistance and I look forward to hearing from you regarding the next step in the consultation process.

Yours sincerely

[Signature]

Nicola Sladden
Chief Legal Advisor
21 May 2007

Ryan McLean
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Consultation on the making of regulations under the Health Practitioners Competence Assurance Act 2003 to allow the Medical Council of New Zealand to elect members to the authority

Thank you for the opportunity to comment on whether regulations should be made under the Health Practitioners Competence Assurance Act 2003 (HPCAA) to allow the Medical Council of New Zealand (the Council) to require that one or more Council members must be elected to the position by the profession.

As Health and Disability Commissioner, my primary concern is that the members of the authorities established under the HPCAA are skilled in the competencies required to fulfill the authority’s statutory role of public protection. The end point of statutory professional regulation must always be that the public receives high quality care from competent health professionals.

I am aware that there is concern within the medical profession about a lack of participation in professional regulation and governance. However, I have some concerns about the proposal that the profession elects a third of the Council’s members. Partial elections are not an effective way of securing expertise and independence in a regulatory body. As noted by influential philosopher Onora O’Neill:1 “If we drop the artificial pretence that expertise and independence are intrinsically incompatible, we can set about securing intelligent forms of accountability by making sure that those who hold to account are appointed for their expertise and are strengthened by measures to secure their independence.”

If there is concern that the Minister of Health cannot be trusted to make independent appointments, this would be better addressed by an independent appointments body, rather than by requiring the Minister to appoint elected practitioners. To command the confidence of both patients and health practitioners, professional regulation it must be seen to be fair and impartial by both the public and the profession. An independent appointments body, as suggested in Liam Donaldson’s Good doctors, safer patients: proposals to strengthen the system to assure and improve the performance of doctors

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and to protect the safety of patients, would be better placed to ensure that the authorities have the appropriate mix of knowledge and skills, as well as the confidence of the public and profession.

However, if the proposed regulations under section 120(4) of the HPCAA are made, the regulations should clearly set out the requirements of the election process. In particular, the regulations should specify criteria for when practitioners are eligible for election, to ensure that the candidates for election have the necessary knowledge and skills. The factors listed in Appendix 1 would not ensure that the elected practitioner has the requisite knowledge and skills to carry out the statutory purpose of protecting public health and safety. Furthermore, some of the criteria listed in Appendix 1 that would exclude a practitioner from being elected appear unwarranted. For example, the fact that a practitioner has been the subject of a Police enquiry does not mean that the practitioner is not qualified to serve in this role.

In conclusion, while the proposed regulations may be necessary to ensure professional confidence in the regulation of the practice of medicine, I am of the view that it would be better to have true independent regulation of the profession. New Zealand moved from a system of pure self-regulation by the medical profession to one of co-regulation in 1996 (with the combination of the Medical Practitioners Act 1995 and the Code of Health and Disability Services Consumers’ Rights). It is a system that has worked well for the public and for the medical profession. The focus now should be on the appointment of skilled independent people to serve on the Medical Council (and other responsible authorities).

I trust that these comments are of assistance. Please contact Legal Advisor Sarah Parker on (04) 4947929, or via email at sparker@hdc.org.nz, if you have any queries.

Yours sincerely

[Signature]

Ron Paterson
Health and Disability Commissioner

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2 Donaldson, L., Good doctors, safer patients: proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients, Department of Health, London, 2006.
Auckland District Law Society Inc
Mental Health & Disability Law Committee
Submission

How to have your say

You are invited to submit feedback on the information set out in this document. In particular, it would be helpful to receive your responses to all or any of the specific questions included at the end of each section and gathered together at the end.

You can download and email the submission form to:

info@healthworkforce.govt.nz

or post your submission to:

    HPCA Submissions
    Health Workforce New Zealand
    National Health Board, Ministry of Health
    PO Box 5013
    WELLINGTON 6145

You can also download this document and other information including dates and venues for the regional public meetings from [http://hpcaactreview.hiirc.org.nz](http://hpcaactreview.hiirc.org.nz).

The closing date for submissions is Friday 26 October 2012.
Submitter’s details
You do not have to answer all the questions or provide personal information if you do not want to.

Carole Curtis
Convenor
Mental Health & Disability Law Committee

Email: carole@legaleagle.co.nz
Organisation (if applicable): Auckland District Law Society Inc
www.adls.org.nz
Position (if applicable): Mental Health & Disability Law Committee

Are you submitting this as:
(Tick one box only in this section)
☐ an individual (not on behalf of an organisation)
☒ on behalf of a group or organisation(s)
☐ other (please specify) ...........................................................................................................

Please indicate which sector(s) your submission represents
(You may tick as many boxes as apply)
☐ Consumer ☐ Family/whnau
☐ Academic/research ☐ M ori
☐ Pacific ☐ District health board
☐ Education/training ☐ Local government
☐ Provider ☐ Funder
☐ Non-government organisation ☐ Prevention/promotion
☒ Professional association ☐ Other (please specify):
...........................................................................................................

All submissions will be acknowledged by the Ministry of Health and a summary of submissions will be sent to all those who request a copy. The summary will include the names of all those who made a submission, unless individuals request that their names not be published.

Do you wish to receive a copy of the summary of submissions?
☒ Yes
☐ No
Questions

Introduction

The Auckland District Law Society Inc (ADLSI) Mental Health & Disability Law Committee (the Committee) welcomes the opportunity to make a submission on the 2012 Review of the Health Practitioners Competence Assurance Act 2003.

We note that a very short time was available for preparation of this submission. The Committee has considered the Review document but in the limited time available it has not been possible to give the proposed changes the full consideration they warrant and only some aspects of the Review are commented on in detail.

The Committee has focused in this submission on its key concerns with the proposals made in the 2012 Review of the Health Practitioners Competence Assurance Act 2003.

The purpose of the responsible authorities (RAs) established under the Act is to protect the health and safety of the public by using the mechanisms provided by the HPCA Act to ensure that health practitioners are competent and fit to practise. In the operational review of the Act undertaken by the Ministry of Health (2007-2009) it was noted that the Act is currently operating largely as intended.

The Committee recognises that the legal mechanisms provided in the HPCA Act have allowed the RAs to develop key programmes and processes focused on the protection of the health and safety of the public. Key achievements under the HPCA Act include:

• Development of general scopes of practice for regulated health practitioners.
• Registration systems that ensure individual members of regulated professions meet the same base competencies whether they are New Zealand or overseas trained;
• Registration processes for overseas trained applicants that can be fast tracked to recognise equivalence in training, qualifications and experience from countries with similar regulatory health environments;
• Recertification and audit programmes to try and identify and appropriately deal with any health practitioners that practise below minimum standards.
• Development of position statements on defined areas of interest have been a useful adjunct to scopes of practice and competencies.
• Development of systems and processes for dealing with complaints and competence issues.
• Proactive collection of workforce data to better assist with health sector intelligence and workforce planning.
• Initiatives aimed at the development of joint competencies, and joint accreditation of educational institutions and programmes with Australian health sector counterparts.

The HPCA Act provides a principled approach to regulation, as well as a prescriptive direction, to allow each RA to regulate their health practitioners, recognising the different health environments within which health services are delivered in New Zealand.

The Committee believe that there is scope to improve regulation in an environment that is undergoing transformational change and that this could be done under the existing HPCA Act.

Answers to specific questions in the review document are as follows:

**Future focus**

1. We want to achieve the best outcomes for patients through integrated care, and so health professional regulation needs to keep pace with how integration improves care and service models. How can the HPCA Act improve this?

   Comment:

   | The HPCA Act provides uniform legislation across all regulated health practitioners managed currently along professional boundaries. |
   | The HPCA Act could further enhance patient outcomes through improvements in integrated care by placing patients/consumers at the centre of integrated approaches to the delivery of health care services, particularly in relation to integrated recordkeeping and requirements in relation to communication between patients/consumers and all of their health professionals. This is particularly relevant to the interaction and collaboration between community and hospital based specialists, allied health professions and GP services. |
   | The HPCA Act could be amended to specifically require greater collaboration between the responsible authorities (RAs) and the practitioners they regulate to improve care and service models through integration. The Act currently requires RAs to liaise with other authorities appointed under this Act about matters of interest and to promote education and training in the profession (s 118). |

2. How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?

   Comment:
The current Act can meet emerging health system challenges and enable a more flexible workforce. As part of national workforce planning the Ministry of Health through Health Workforce New Zealand (HWNZ) can work with RAs and other stakeholders to improve the collection, collation, analysis and dissemination of comprehensive, accurate, comparable, timely information about the registered health practitioner workforce and use this information to develop recruitment and retention strategies.

The current functions of the RAs are set out in the HPCA Act s 118. This includes prescribing the qualifications required for scopes of practice within the regulated professions. The current Act allows RAs to place conditions on scopes of practice, to issue limited scopes of practice, and to consider extended scopes to enable the health workforce to fulfil the needs of a changing healthcare environment. Changes to scopes of practice can be made at the regulatory level without the need for changes to legislation.

Using the HPCA Act to promote a more flexible workforce will require individual health practitioners to explore different ways of working as formally recognised scopes of practice will potentially evolve in to areas of practice traditionally not provided for under current RA scopes of practice.

The ability to prescribe scopes is enabling as we move into an era where professional boundaries become more blurred. Generic skill sets and modular activities may need to be identified and training programmes accredited that could be accessed by a variety of professions. For example prescribing of medicines and specialised equipment, and the ability to request laboratory tests.

Change could be further enabled through accrediting small programmes for specific skills sought outside of general scopes of practice. Credentialing is a mechanism already available under the HPCA Act.

3. How can the HPCA Act promote education and training that has a wider focus, such as effective ways of working in teams, improved communication skills and support for consumers’ self-management?

☑ Yes
☐ No
☐ Not sure

Comment:
To promote teamwork, each RA needs to ensure that its practitioners have the general competencies of teamwork, good communication, and the ability to understand each others’ roles.

Under the HPCA Act, the RAs accredit the undergraduate programmes that train New Zealand educated health practitioners. Through the accreditation framework, the RAs can ensure that New Zealand educated health practitioners meet the competencies required to effectively work in teams and to support consumers’ self-management.

Undergraduate programs are training health practitioners to work in interdisciplinary and inter-professional clinical environments. Competencies as defined by each RA include recognition of the behaviours and capabilities needed for effective teamwork. Practitioners are required to demonstrate continuing professional development activities that ensure the practitioner continues to meet the standards set by the RAs.

The above mechanisms are already in place under the HPCA Act. Further legislation may not be the best mechanism for promoting teamwork. There are many environmental factors that affect teamwork and collaboration that are beyond the scope of regulation. Instead, it may be better suited to guidelines and memoranda of understanding provided within specific healthcare environments or agreed upon intra-professional courtesies.

4. Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?
   - ☒ Yes
   - ☐ No
   - ☐ Not sure
   
   **Comment:**

   Under the current Act there is already scope for further streamlining of standards and codes. RAs have, for example, developed some shared principles relating to standards and codes through the co-operation and goodwill inherent in the work of the Health Regulatory Authorities of New Zealand (HRANZ). All RAs are typically included in any consultation process undertaken in this regard.

   Currently all responsible authorities (RAs) are working towards a shared secretariat which should eliminate a lot of duplication, where possible reduce costs and facilitate the alignment of codes and standards whilst still preserving profession specific differentiation where this is needed in order to improve quality.

5. Do we have the right balance between broad scopes of practice and sufficient provision of information to inform people about what they can expect from a health practitioner?
Currently under the HPCA Act scopes of practice are very broad. This supposedly provides flexibility whilst still enabling practitioners to define their area of interest. More information however needs to be provided to inform the public on what they can expect from a health practitioner.

The issue of informing the public about the role and work of health practitioners is one however that does not require legislation, but instead could be resolved through cooperation between RAs, professional bodies, the Ministry of Health and consumer advocacy groups through their websites, publications and other means including making business information about registered practitioners freely available.

6. Could/should RAs have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?

☐ Yes
☒ No
☐ Not sure

Comment:
There is a role for a health committee shared by all the RAs with mandated
policies and practices in place to support the pastoral care of health
practitioners. Such a committee would ensure the preservation of the
professional distance required for the RAs to fulfill their statutory obligations
under the HPCA Act whilst also meeting the needs of practitioners and
addressing public health and safety concerns to support the sustainability of
the workforce. Such an approach is possible under the current
legislation.

The primary responsibility for health and pastoral care related matters should
however sit with the health practitioner with support from employers and
professional bodies as appropriate. The key value underpinning the HPCA Act
is the accountability of individual health practitioners for their own clinical
practice and the application of professional judgment in their clinical practice.

Keeping health practitioners in the workforce for longer is desirable provided
they stay technically competent and able to engage with new technologies that
are increasingly being used in the delivery of efficient patient centred care.

Many RAs require a self-declaration in relation to fitness to practice issues
when practitioners apply for an annual practising certificate. What is not clear
currently is the extent to which RAs actually actively manage and monitor
practitioners in this situation. Of concern also are the practitioners that do not
self-declare health or other fitness to practice issues and work without the
additional oversight by the RA intended by the self-declaration question to
ensure the health and safety of the public.

The challenging time for supporting a health practitioner is when a practitioner
is under investigation for competence or complaints and the RA approach must
of necessity change from pastoral care to that of a regulator investigating
breaches of the Act where the ultimate outcome may have serious
consequences on the ability of a practitioner to remain in the profession.

**Consumer focus**

7. Does the HPCA Act keep the public safe, involve consumers appropriately in
decision-making and assist in keeping the public informed?

☐ Yes
☒ No
☐ Not sure

Comment:
The primary purpose of the HPCA Act is to protect the health and safety of the public. The Act has a strong consumer focus.

RAs could consult more widely amongst consumer advocacy groups and consumers generally on the services provided by health practitioners and the information on them that is currently publicly available.

The media have an important role to play in keeping the public well informed and ensuring that public perception accurately matches the reality.

The Ministry of Health could have a greater more proactive role in educating the public on all legislation and other matters relevant to patient care within the New Zealand health sector.

The Office of the Health and Disability Commissioner could also assume a more central role in keeping the public informed.

It is currently very difficult for consumers to access qualitative information on individual health practitioners. The information available varies between RAs but generally only basic information relating to date of registration and the holding of an annual practising certificate relating to scopes of practice is available on the public registers of health practitioners. Any conditions (including supervision) placed on a practitioners right to practice may only be indicated on an RA website with a ‘yes’ or ‘no’ with a direction for the public to contact the relevant RA for further information. Information relating to locality of a practice is not consistently provided by the RAs.

With the goodwill and commitment of the RAs enhanced communication with health consumers is possible under the current legislative framework.

There are currently a number of sources of statistical information that could potentially be used to greater effect to inform questions relating to quality of care, competency and safety issues. This information is held by health insurers including ACC that are uniquely positioned to have a view on issues relating to individual health practitioner competency, patient outcomes and the cost effective delivery of services.

Additional information could be made available to help consumers in the selection of health practitioners whilst still ensuring appropriate protection to individual consumer and health practitioner privacy.

Consumers are not currently uniformly involved in their own ongoing care particularly where this involves referrals between GP, specialist and allied health services. Copies of correspondence, laboratory test results most commonly flow only to a GP unless copies are specifically requested by consumers.

On the other hand self-referral, for example to a physiotherapist under an accident compensation claim may not link back to a GP/patient centred model.

Given that patient documentation is generally now scanned in to practice management sytems copying patients in to the process has never been easier.

Access issues in relation to specialised care can be problematic particularly in rural and smaller centres.
8. Is information from RAs readily available, particularly as it relates to practitioners and the transparency of complaints and complaint processes? If so, is this information made good use of by the public?

☑ No

RAs have the ability to publish detailed current information related to their complaint policies and processes on their websites.

Greater collaboration between RAs, employers, professional bodies, the Health and Disability Commissioner, and the Ministry could be undertaken to develop guidelines that while complying with the principles of natural justice are able to ensure more information is publicly available relating to complaints and complaint processes.

RAs are cautious about releasing information about an individual complaint to anyone other than the parties involved. RAs must maintain an open mind until evidence has been considered and provide an opportunity for a health practitioner to be heard. A very high threshold exists behind closed doors to determine whether a complaint should be taken further within the processes provided for in the HPCA Act. RAs must balance competing principles of openness and transparency, RA accountability, justice being seen to be done, public interest in knowing the name of health practitioners that are subject to complaints, the risk that other health practitioners may be unfairly impugned, presumed innocence of a health practitioner until the facts are established, the impact on the health practitioner's family and the disproportionate impact that naming a health practitioner may have on his or her career and the possibility of the inappropriate sensationalising of errors made by health practitioners.

We note that the HPCA Act does prescribe some situations where matters must be referred to a Professional Conduct Committee. Under the HPCA Act RAs do have the ability to consider whether any interim action is necessary to protect patients. Serious threats to patient safety will require prompt action. Some non-urgent cases however may involve many weeks of investigation, submissions, consideration and deliberation.

Consumers should be able to review RA decisions or find out information using the Official Information Act 1992. There is inconsistency currently in the information released by the 16 RAs.

Consumers can challenge RA decision making through the judicial review process as being illegal, unfair or unreasonable. For example a decision by the RA not to take a complaint against a health practitioner any further. Judicial review allows an applicant to challenge in the High Court the exercise of a public power. In a judicial review the focus is generally on the decision-making process however rather than the actual decision.

From a consumer perspective judicial reviews can be slow, stressful and expensive.

RAs are aware of the need to protect their decisions against judicial review and this of itself provides some comfort to consumers despite the lack of transparency. RAs will typically try and ensure that a decision was made under the proper provisions of the Act, the statutory process was followed, all relevant considerations were taken in to account, the case was considered on its merits rather than via a predetermined policy, and adversely affected parties were properly consulted and had their submissions considered with an open mind.
The outcome of a judicial review may include declarations about the way a decision was made, setting the decision aside as unlawful, directing the person who made it to reconsider it, and making an order for costs.

Of particular note however from a consumer perspective is the fact that provided actions are lawful, fair and reasonable the Court will generally show deference to a decision-making body with specialist skills or expertise. (For example the Medical Council in Wislang v MCNZ.) This may seem an unsatisfactory outcome from a consumer’s perspective.

9. Do we have the right balance of laypeople to health professionals on RA boards?
☐ Yes
☐ No
☒ Not sure

Comment:

Currently lay members seem to be appointed on the basis of specialist business knowledge relating to law, accounting, governance etc. Most lay members also see themselves as bringing an independent consumer perspective to a RA.

With regard to the future representation on RA Boards a helpful perspective to consider might be to have more diverse representation from various health professions on profession specific Boards to further encourage collaboration and communication between the various professions within the health sector.

When considering the criteria for the appointment of Board members, cultural input is valuable as well.

Currently setting the criteria for Board members is the responsibility of the Minister of Health, and each board is asked what skills are needed when considering new members. HPCA Act s 120(4) gives the power to have some members of RAs elected to Boards under regulations made under the Act.

10. Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?
☒ Yes
☐ No
☐ Not sure

Comment:
New Zealand could certainly consider introducing consumer forums. A feasibility study (key concerns) followed by a pilot programme to determine what might be achieved within the New Zealand context could be established under the auspices of the Health & Disability Commission.

Consumer forums could be used in the development phase of new initiatives rather than the consultation phase when a proposal is well developed.

Consumers could also potentially be contacted for feedback in the future as part of the audit processes associated with recertification of practitioners.

**Safety focus**

11. Do we currently make the best use of legislation to keep the public safe from harm when accessing health and disability services?

- [ ] Yes
- [ ] No
- [x] Not sure

**Comment:**

The health and safety of the public is fundamental to the HPCA Act. RAs have policies and procedures in place designed to fulfill their obligations under the Act and are committed to ensuring the ongoing competence (minimum standards) of health practitioners.

There are likely to be many competence related issues however that do not of themselves make the threshold for formal consideration by an RA as a complaint but taken together are reflective of competency issues that may be impacting on the health and safety of the public.

Recertification and audit processes are not of uniform quality across RAs nor are accredited assessors, moderators and auditors always used by RAs in the fulfilment of their obligations under the HPCA Act.

Section 34, regarding employer notification, requires an employer to make a final decision before notifying an RA of an issue. This is a good minimum bar to ensure that issues are brought to the RA, but there may be room to take a more supportive approach in the early intervention of competence issues. Complaints managed within an organisation may not be notified to an RA.

12. Can we make better use of other legislation or employer-based risk management systems and reduce reliance on statutory regulation?

- [ ] Yes
- [ ] No
- [x] Not sure

**Comment:**
Many health practitioners are self-employed, or work in private practice rather than a DHB environment. The employer based risk management model proposed in the review document seems to focus on health practitioners working within DHBs. Health care delivery, regulation and competence are not core business for many employers. Many smaller businesses in particular do not have the human resources capability and support to regulate staff and even within the DHBs, some of the smaller DHBs are reducing their support for continuing professional development activities.

Credentialing models could be developed further to make better use of the potential of employer based risk management systems and to reduce reliance on statutory regulation where it is appropriate to do so recognising the investment in initial and on-going skills, training and experience made by individual health practitioners and the recognition given to their career progression under the current system of individual practitioner registration.

13. What more needs to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?

Comment:

This is a larger piece of work that will require consultation with key organisations, professions, regulatory bodies, and the public. It should be recognised that there is strong DHB focus in some policies and legislation that will not suit all health care professions or environments, e.g. national reportable events may not easily translate to primary care environments where the RAs are being asked to focus.

☐

14. Is the HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?

☐ Yes

☐ No

☐ Not sure

Comment:
The HPCA Act is clear about the level of risk that needs to be regulated. HRANZ have agreed upon definitions for risk of harm and risk of serious harm to ensure that regulation is consistent across the professions.

The concept of tiered regulation needs to be considered relative to the level of risk posed. Some professions are inherently riskier than others.

The current list of activities restricted to particular health practitioners under s 9 HPCA Act could be further developed recognising however that it is not just activities that pose risk. Practice environment or type of patient/client may also impact on risks.

15. Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?

Comment:

Sole practitioners working in complete isolation, rather than as part of a multi-disciplinary team may pose a greater risk of harm. Developing a high risk practitioner profile would assist in identifying early warning signs and ensuring that practitioners receive the support they need.

There are already mechanisms in place that could be enhanced to mitigate these risks. For example recertification requirements for sole practitioners could require more frequent audit participation with a greater focus on identification and reflective statements on the risks of being in sole practice. Restrictions could also be imposed on new registrants preventing them from working in sole practice for a certain number of years.

16. In the case of groups of practitioners that might be considered high risk, would it be useful for a risk-profiling approach to be applied by RAs?

☐ Yes
☐ No
☐ Not sure

Comment:

It would be beneficial to develop a high risk profile that considers high risk tasks as well as other factors such as practice environment. However root cause analysis tells us that simple activities in combination can contribute to adverse events.

Cost effectiveness focus

17. What role do RAs play in considering the cost impacts of their decisions and the cost benefits of regulation?

Comment:
As public entities the RAs are subject to the Public Audit Act 2001. Auditors appointed by the Office of the Auditor-General (OAG) are required to consider performance, waste and probity in relation to expenditure, policies and practice in accordance with the OAGs best practice guidelines: *Controlling Sensitive Expenditure—Guidelines for Public Entities*, *Charging Fees for Public Sector Goods and Services*, and *Audit Committees in the Public Sector*. The OAG audit process also looks at compliance with relevant laws and regulation, conflicts of interest, related party disclosures and the identification, documentation and reporting of fraud risk factors.

Cost and value for money is considered in the setting of fees by RAs. Any change in fees typically goes through a consultation process and is gazetted.

RAs generally consider fees on the basis that these will be paid for by the individual practitioner, and for many health practitioners this is the case. There is no evidence indicating fees are being collected or applied irresponsibly.

Other costs of regulation that are borne by practitioners and their employers are the costs of continuing professional development (CPD). CPD is an inherent part of professional practice and should be undertaken whether or not a profession is regulated. There is an assumption in the document that CPD is costly and that that cost is born by the employer. Not all professions have the same contracts. Many smaller employers do not provide CPD as part of employment and many DHBs are decreasing funding for continuing education. CPD does not have to involve an expensive activity. Self directed learning is an integral aspect of CPD.

An audit of RA performance and effectiveness of outcomes could be beneficial against a set of agreed indicators.

Economies of scale, standardisation of templates, for example in relation to annual reporting, and the greater use of technologies, for example, online processes, may provide more cost effective support to the profession and employers where this can be achieved without detriment and with possible benefit to the health and safety of the public.

Safety in health and disability services remains a critical consideration in any focus on the cost effectiveness of regulation.

18. Should the HPCA Act define harm or serious harm?

- [ ] Yes
- [ ] No
- [ ] Not sure

Comment:
Currently HRANZ works from a common definition of harm and serious harm. This is published in an online document available on all RA websites. It provides a uniform level of risk recognised across all professions. As amalgamation progresses, and depending on potential credentialing or changes to the regulatory environment and legislation, it may be beneficial to have this clearly stated in the HPCA Act so that uniformity is not lost. Defining level of harm is useful for obtaining a common language and benchmarking; however, RAs should continue to look at major complaints and trends in complaints and use these to plan education and guidance for health practitioners that may prevent unpredicted harm.

19. Is HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?
   ☒ Yes
   ☐ No
   ☐ Not sure

Comment:

The HPCA Act is clear about the level of risk that needs to be regulated. Root cause analysis suggests however that less risky activities in combination can be problematic and result in serious harm.

The Review document emphasises inter-professionalism and improving the ability to undertake shared practice. There are however a number of complexities and risks associated with this approach. For example, shared scopes of practice have the potential to create a less transparent health care role that would be difficult for the consumer to understand.

Activities that are unique to a workplace have the option to be credentialled to reduce risk or a local process could be accredited by the appropriate RA.

20. Is the right set of regulatory options being applied to manage the risk of harm to the public that different health professions might pose?
   ☐ Yes
   ☐ No
   ☒ Not sure

Comment:

The functions of the RAs are defined in s 118 of the HPCA Act. Additional mechanisms could be added to s 118 to provide greater flexibility and oversight of health practitioners to manage the risk of harm to the public.

Further workforce data is needed to inform a tiered system of regulation that includes 'newly recognised' health practitioner related qualifications created...
20. Could the way RAs administer their functions be improved?
- Yes
- No
- Not sure

Comment:

The amalgamation of secretariat functions is underway and should be able to achieve some of the goals described in the Review document. The final determination of the form this might take including decisions on whether to amalgamate both regulatory and administrative functions and the savings and efficiencies that potentially could be achieved have not yet been determined.

21. Should RAs be required to consult more broadly with relevant stakeholders?
- Yes
- No
- Not sure

Comment:

RAs do consult widely on major decisions and initiatives beyond the required consultation on scopes of practice, prescribed qualifications, and fees. Additional community and employer forums may provide feedback that will inform change in the health sector.

22. Should the number of regulatory boards be reduced, as in the UK?
- Yes
- No
- Not sure

Comment:
As amalgamation progresses natural combinations of RAs will in the absence of forced amalgamations become apparent over time.

The HPCA Act could be enabled to recognise tiers of risk and the regulation of additional designated groups of health practitioners.

24. What is the ideal size of RA boards?
Comment:

The ideal size for a RA board is one that is small enough to work effectively yet large enough to ensure that key interests, skills and experience are adequately represented at the board table.

25. Are there other issues you would like to raise?
Comment:

Many of the objectives presented in the Review document can be achieved without any change to the HPCA Act while other stated desired outcomes are unlikely to be achieved through a review of the HPCA Act but could be achieved through other means.

The Committee support the regulation of health practitioners via a certification/licensure model that meets the health workforce needs of New Zealand whilst still maintaining the key focus of regulation on the health and safety of the public.