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: (name) Withheld

Address: (street/box number) (town/city)

Email:

Organisation (if applicable): Te Tiriti and Bicultural Advisory Committee of New Zealand Association of Psychotherapists

Position (if applicable):

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 The summary will include the names of all those who made a submission, unless individuals request that their names not be published. 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
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:

A flexible workforce would recognise that indigenous groups have perspectives on healing and health that may not be present in the mainstream health system. The HPCA does not mention Te Tiriti o Waitangi and therefore makes it hard for indigenous practitioners to be recognised. Recognising responsibilities under Te Tiriti would broaden the scope of the HPCA and better provide for indigenous populations. It would be good to see, for example, Māori pathways to registration recognised or developed by RAs.
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:

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:

While ethical systems have common threads we would be cautious about too much standardisation which may mean that a profession may have key values recognised.

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:

We suggest that all RAs include recognition of Te Tiriti o Waitangi in their scopes of practice. With the rapid increase in the number of people identifying as Māori we consider this scope of practice will be in greater demand, particularly in the field of psychotherapy where psychological distress will be treated.
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:

New Zealand Association of Psychotherapists has looked after the pastoral needs of its members by requiring they be in regular supervision. For RAs to take on this role would probably mean an increase in fees and staffing which is not desirable.

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:

Professional associations with robust complaints procedures and strong Codes of Ethics will do more than legislation to keep the public safe.

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:
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:

_Aotearoa New Zealand is a much smaller society than UK and consumers are generally able to express their concerns. Consumer forums may be expensive and not well used._

**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
☒ Not sure

Comment:

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:

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:

Psychotherapy is not a high risk category and should not be more highly regulated.
15. Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?

Comment:

Psychotherapists rely on regular supervision and discussion of the risks of their work to manage risk. The low level of complaint suggests this model is effective.

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:
18. Should the HPCA Act define harm or serious harm?
   - Yes
   - No
   - Not sure
Comment:

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:

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

☐ No

☐ Not sure

Comment:

There could be more consultation between RAs so that efficiencies are shared and wisdom is passed on. Learning from each other, particularly for a new RA would save time and costs.

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:

If this could be done without loss of service to the smaller RAs it is worth considering. However, it would not be good to have some RAs feeling they had insufficient access to resources and administrative services.
24. What is the ideal size of RA boards?

Comment:

6 – 12 members

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

Comment:

We regard the omission of reference to Te Tiriti o Waitangi as a serious deficit in the HPCA Act. This allows health professionals and RAs to choose to ignore needs of Māori. There are no policy statements about Te Tiriti and the safety of Māori. This makes the development of Māori pathways into the professions optional rather than essential. We would like to see the Act recognise the need to encourage the training and support of indigenous practitioners.
## 2012 Review of the HPCA Act 2003
Response provided by the Nursing and Midwifery Leadership Team at Southern District Health Board

### Summary of discussion document Questions

<table>
<thead>
<tr>
<th>Future focus</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>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?</td>
<td>We feel this is good legislation as it currently stands and is not a barrier to integrated care. We feel that this is more the responsibility of the regulatory body for the various professions and those within the professions and their employers to facilitate integration and improvement of care and service models. There is a risk that changing the act to improve this may not achieve this desired outcome. As an example of the above we do not feel that positions such as Healthcare Assistants should be regulated – in our secondary/tertiary care setting they are roles that have limited formal training and as such should continue to practice under the direction and delegation of a Registered Nurse. We do recognise the challenges of the aged care setting in particular, but do not believe that further regulation will necessarily assist this.</td>
</tr>
<tr>
<td>2. How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?</td>
<td>From our perspective the scopes as set by the regulatory authorities are already broad enough to allow flexibility. This is clearly able to occur within the nursing scope and evidenced by scope changes made by Nursing Council under the existing Act to extend the scope and thereby promote greater flexibility in the nursing workforce. The midwifery scope of practice is narrower, but again broad enough to accommodate the needs of the profession.</td>
</tr>
<tr>
<td>3. How can the HPCA Act promote education and training that has a wider</td>
<td>Not really within scope of Act. This aim could be enhanced through the</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Focus, such as effective ways of working in teams, improved communication skills and support for consumers’ self-management?</strong></td>
<td><strong>Regulatory bodies’ reviews of education curricula and encouraging of the professional groups to take leadership in this regard. We would support ongoing education, but not just academic knowledge but also cultural competencies, empowerment of consumers and promotion of self-management where appropriate.</strong></td>
</tr>
</tbody>
</table>
| **4. Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?** | **We are unsure how the HPCA Act would address or enhance common learning or indeed if this would be desirable, notwithstanding the above and a desire to enhance inter-professional learning opportunities.**  
**There may be some advantage in standardisation of codes of conduct and ethics as under the current act all practitioners are dealt with in a similar manner regardless of the regulatory authority.**  
**We don’t believe there is a need to have a platform where there are commonalities - to some degree this is already provided within the current legislation.**  
**If a health professional wants to work in another area of health- there are already some provisions for transferability within the tertiary organisations through RPL (recognition of prior learning)** |
| **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?** | **Unsure of the meaning of this question and there may be a word missed out.**  
**Yes, the issue is more how the public are informed of what they can expect from registered practitioners and what practitioners are not registered under the Act. For example a dietician and a nutritionist.** |
6. Could RAs have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?

We believe this is an employer, professional body and industrial representation issue – with exception of health issues and they are already having mandated through a RA process. There is a risk of tension between the paramount of public safety and perceived support of the practitioner if this became the responsibility of 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?

Yes, but this is an area that could always be improved. The challenge is seeking appropriate consumers in the first instance and then sharing information with the public per se.

Examples from consumers of midwifery care and their attempts to influence the profession and the RA spring to mind.

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?

Relationships with individual RA’s and more particularly their representatives are very important and form the basis of ongoing interactions. Opportunities to meet face to face either in annual forums such as the midwifery council undertake or the DHB by DHB visits that nursing council undertake are very valuable to share information and build relationships.

We are unsure what is meant by “complaints and complaint processes”, but expect that this refers to actions by the public and not referrals made to RA’s by employers or practitioners. Transparency and information sharing in this regard is not always evident to the DHB from our experiences, but it must be remembered that the process is between the RA and the practitioner and only the outcome needs to be shared. Timeliness of the process sometimes a factor

Again from a midwifery perspective there is evidence of the RA’s actions not being accepted by consumers. The action of the council and remedial action of the practitioner have to be weighed up
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Do we have the right balance of laypeople to health professionals on RA boards?</td>
<td>Yes from our perspective against the publics need for information.</td>
</tr>
<tr>
<td>10. Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?</td>
<td>There are already opportunities with consultation and membership of committees. Unfortunately consumer forums would most likely become avenues for those consumers with particular grievances to re-litigate these.</td>
</tr>
<tr>
<td>Safety focus</td>
<td></td>
</tr>
<tr>
<td>11. Do we currently make the best use of legislation to keep the public safe from harm when accessing health and disability services?</td>
<td>Yes we would like to think that this is the case.</td>
</tr>
<tr>
<td>12. Can we make better use of other legislation or employer-based risk management systems and reduce reliance on statutory regulation?</td>
<td>No from our DHB perspective we do not believe you can legislate for an individuals own actions and low level resolution, not involving the RA is desirable. This is something for the employer to take responsibility for and have processes established to ensure this is the case. For small employers there may be role for RA’s to provide advice and support regarding performance review and deficit management to potentially avoid the input of the RA.</td>
</tr>
<tr>
<td>13. What more needs to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?</td>
<td>We don’t consider there are overlaps, unless this is referring to the HPCA Act, the HDC Act and ACC legislation for example and the potential for practitioners to be dealt under all of these. The HPCA Act allows for sharing of information which should result in greater integration rather than overlaps.</td>
</tr>
<tr>
<td>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?</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>15.</strong> Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?</td>
<td>Up to the practitioner to manage, raise with their professional body or employer. Isolated practice does not only occur in areas of sole practice. One would hope that the ongoing competence expectations of the individual RA’s would give opportunities for those in sole practice to manage clinical practice risks. The onus is on the individual to avail themselves of opportunities however. Maybe the use of electronic communication either written, video link could help by providing a forum to raise issues or learn from peers or experts out of the geographical location.</td>
</tr>
<tr>
<td><strong>16.</strong> 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?</td>
<td>If risk profiling was considered in the context of failing to participate in ongoing competence expectations or with repetitive behaviours or actions being reported this may be of value, but even then the effort to identify and then follow-up these practitioners would have doubtful benefit.</td>
</tr>
<tr>
<td><strong>Cost effectiveness focus</strong></td>
<td></td>
</tr>
<tr>
<td><strong>17.</strong> What role do RAs play in considering the cost impacts of their decisions and the cost benefits of regulation?</td>
<td>They appear accountable for their decisions currently - NCNZ and NZMC seem to be very mindful of cost for individuals and employers</td>
</tr>
<tr>
<td><strong>18.</strong> Should the HPCA Act define harm or serious harm?</td>
<td>No – this needs to sit with the public – they define what they consider harm and then report on that basis. There are also other infrastructures that do this e.g. HDC, Health Quality &amp; Safety commission- it would potentially create duplication and confusion The definitions suggested would be extremely difficult to assign. We already have a severity assessment system for adverse events. Any move to assign harm or serious harm would only add to the complexity of examination of events and potentially contrary opinions from either side of the argument.</td>
</tr>
<tr>
<td><strong>19.</strong> Is HPCA Act clear about the level of risk that needs to be regulated by</td>
<td>Yes – clear, no need to for change</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>statute? If not, what would help to improve the match between level of</td>
<td>Yes</td>
</tr>
<tr>
<td>risk and level of regulation?</td>
<td></td>
</tr>
<tr>
<td>20. Is the right set of regulatory options being applied to manage the</td>
<td>There is always potential to improve, but overall we are comfortable</td>
</tr>
<tr>
<td>risk of harm to the public that different health professions might</td>
<td>with the administration of both the nursing and midwifery councils. The</td>
</tr>
<tr>
<td>pose?</td>
<td>timeliness of investigation processes could be an area of improvement.</td>
</tr>
<tr>
<td>21. Could the way RAs administer their functions be improved?</td>
<td>They already consult very broadly and often state this is a requirement of the HPCA</td>
</tr>
<tr>
<td>22. Should RAs be required to consult more broadly with relevant</td>
<td>Our experience is predominantly with the nursing and midwifery RA’s and</td>
</tr>
<tr>
<td>stakeholders?</td>
<td>we would not like to see them rejoined or integrated with any other.</td>
</tr>
<tr>
<td>23. Should the number of regulatory boards be reduced, as in the UK?</td>
<td>This isn’t something we cannot answer as the size of the board should</td>
</tr>
<tr>
<td></td>
<td>be such that it can affectively operate. We would comment that the RA board for nursing and midwifery is already lean.</td>
</tr>
<tr>
<td>24. What is the ideal size of RA boards?</td>
<td>In discussions held with other DHB representatives regarding a collective</td>
</tr>
<tr>
<td></td>
<td>view, it has become evident that the current HPCA Act is functional and</td>
</tr>
<tr>
<td></td>
<td>that attempts to change the act to improve areas of concern may not in</td>
</tr>
<tr>
<td></td>
<td>fact attain the desired affect. Any changes made may in fact have</td>
</tr>
<tr>
<td></td>
<td>undesired consequences while not addressing the known or perceived issues.</td>
</tr>
</tbody>
</table>
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: (name) Withheld

Address: (street/box number) (town/city)

Email:

Organisation (if applicable):

Position (if applicable):

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
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 a much wider education of the role of the optical profession and its various components ie: the role of the optometrist and the role of the dispensing optician

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 role of the dispenser in optics is being encoded whilst "the boundaries are increasing shifting" away from regulating the dispensing side of optics, a key value in optics is not operating effectively in this changing environment.

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?
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:

Consumers need information as to the role of the dispensing optician in optics, to make a good decision, about the health practitioner they choose.

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:

Currently there is a lack of transparency. The average person in the public sector has limited or no knowledge of the HPCA.

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:

Through consumer forums etc to ascertain the level of public knowledge into the roles of the optician/optometrist/ophthalmologist

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

☐ Yes
Prior to and during the assessment process there needs to be a procedure of enquiry into the person

**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
- [x] No
- [ ] Not sure

Comment:

A risk-based regulation should be considered eg compliance vs certification in the dispensing of prescription of safety specs. The markings of heights/measurements of frames etc is essential in the completion of "safe" specs.

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
- [x] No
- [ ] Not sure

Comment:

Due to lack of public knowledge

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

- [ ] Yes
- [ ] No
Not sure

Comment:
The experience of the layperson used in the process was that this person had no education by the board involved.

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:
Public forums conducted by professional bodies is a must and a non-threatening way to educate the public.

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:
As explained above, due to lack of education on correct prescribing for the use of the patient's optical needs ie progressive lenses: ill fitting frames, optical heights not measured correct, types of lenses not optimal for patient use

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:

Employers using registered Dispensing Optician vs those using unqualified who have no registration requirements and are cheaper to employee

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 Board has not educated the public in their role at all they target the Registered practitioner only. Meanwhile the Health Board is equally responsible for lack of education.

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:

Need to encourage public for input of sound optical practice

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

Comment:
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:

1. Corporate organisations cutting eye health appointment times
2. Use of unqualified staff to dispense
3. Optometrists lack of dispensing skills due to educational restrictions

Cost effectiveness focus

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

Comment:

Not a level playing because of the use of unqualified staff. Only Optometrists need to be qualified to run an Optical practice.

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

☒ Yes
☐ No
☐ Not sure

Comment:
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:

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
☐ No
☐ Not sure

Comment:
By insisting on only qualified/educated staff working for the RAs this would exclude the confusion between the role of assessor and the role of the educator. A level of assessment is essential to start the process.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   ✗ Yes
   □ No
   □ Not sure
   Comment:
   Unacceptable time lapse

23. Should the number of regulatory boards be reduced, as in the UK?
   □ Yes
   □ No
   ✗ Not sure
   Comment:
   Not if this suggests all health professionals be banded together as the expertise in each branch of the professions is so unique

24. What is the ideal size of RA boards?
   Comment:
   No ideas - would depend on the body of persons being supervised

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

The lack of pastoral care for those being supervised is of considerable concern. In the case of safety spectacles there is a lack of industry knowledge/public knowledge and this is of concern.
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: Withheld
(name)

Address: (street/box number)
(town/city)

Email:

Organisation (if applicable): Dietitians, Nutrition Services, Auckland District Health Board

Position (if applicable):

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):

Professional Group within a DHB.

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

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:

We see no significant barriers at present

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

Comment:

RAs ability to prescribe educational qualifications e.g. for Dietitian Assistants

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?
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 generic Code of Ethics (with profession-specific add-ons) offers advantages of consistency across professions and would be helpful for disciplinary hearings.

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?

Not sure

Comment:

Not sure how to do this though, as scopes are incredibly difficult to describe to people and mostly very broad in nature. However prescriptive scopes would defeat the goal of team working etc.

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
This is already a component in RAs work which is confidential, so professions never learn about that, although it might be better advertised. There is a conflict of interest for RAs between managing a professional misconduct investigation, and in providing pastoral care.

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:

All RAs have access to existing consumer groups. It would not be improved by adding more lay-members to an RA. Any new costs to RAs of involving consumers would need to be met by the Ministry, not the RA.

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:

Unless a HDC case or a court hearing, the results would be confidential, so the public would never know. Media interest in HDC cases is already high and well reported. Unsure how further publicity would help.

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

- Yes
- No
In the case of the Dietitians Board the balance is good at 2 lay / 7 professional (or 2 lay / 8 professionals). Health professionals undertake most of the work.

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:

A shared forum at Ministry expense could be useful.

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:

What is safe? People practice differently at two ends of a spectrum. Some are on the fringes and not covered by HPCAA. Overall HPCAA has worked well.

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:
Perhaps ACC, and Health and Disability, but note that there is a significant private sector not covered by employer risk, and also a lack of uniform employer approach.

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:
Self employed and sole practitioners need more support as their overall quality and safety of services are not covered by an ‘employer’ such as a DHB. Need to review outcomes from scheduled activities to see if working well, and strengthen as needed. (NB: Dietitians interest in enteral and parenteral nutrition).

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:
Same comment as for 13, above

15. Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?
Comment:
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:
Might be advantageous, but might be seen as unfair to those in isolation, such as private practice. However in reality these practitioners most often pose a risk.

Cost effectiveness focus

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

Comment:
RAs take a key role in considering APC costs. Re-education / return to practice / overseas trained constraints – all cheap in comparison to costs of a disciplinary process.

Should APC be bi-annual or annual?

Should the HPCA Act define harm or serious harm?

☐ Yes
☐ No
☑ Not sure

Comment:
Case by case approach. The ACC model has some difficulties

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:

See comment for question 13

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:

See comment for question 13

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

☒ ☐ Yes
☐ No
☐ Not sure

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

Comment:

Already in place

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

Comment:

See response to 21 above

24. What is the ideal size of RA boards?

Comment:

Dietitians Board with 7-8 professional and 2 lay members works well

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://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: (name) Annabel Whinam

Address: (street/box number) PO Box 10-202
(town/city) Wellington

Email: registrar@podiatristsboard.org.nz

Organisation (if applicable): Podiatrists Board
Position (if applicable): Registrar

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
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 Board would support a better data collection system that could be used by the individual Responsible Authorities to gather accurate information across a sector.

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 Board would not like to see the podiatry scope of practice become too specific and agrees with HWFNZ in keeping scopes broader and generalised, to enable the growth of different skill bases for practitioners. It would encourage a general scope that enhances interdisciplinary working where any team member can take the lead “case management” role.

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?
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:

Responsible Authorities can share and work together on some policy documents as many aspects covered apply across a number of health professions. Standardising the Code of Ethics is a good idea as all health practitioners generally have the same code, however the Code of Practice is different in that it is more profession specific.

Look at the AHPRA model to streamline RA functions.

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:
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 would fit better within the professional associations and societies and may not be fully appropriate for RAs, however RAs do undertake a degree of this in advising practitioners in certain situations.

RAs could enhance pastoral care by including requirements for peer review, supervision and audit requirements within their CPD programmes.

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:

Lay people provide consumer/lay input. General information on what the consumer can expect from a health professional already exists in the rights and responsibilities information from HDC.

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:
9. Do we have the right balance of laypeople to health professionals on RA boards?
   - Yes
   - No
   - Not sure
   Comment:
   The Board feels that current balance of lay and professionals works well and would not want to see an increase of lay members to what we currently have. Lay input is invaluable as is profession specific knowledge especially when dealing with complaints.

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:

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:
    Better mandatory reporting and processes via HDC information posters would be beneficial.
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:

Yes, as an adjunct to RA roles, but not to replace the need for the independence of a RA.

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:

Ensure that regulation regarding children and misconduct reporting is adequate to provide protection. Standardising processes across RAs for complaints, and ensuring that penalties are consistent and fair across professions.

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:

Within the safety focus area for all practitioners, peer review has been shown to improve practice and this is to be encouraged.

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

Comment:

The Board feels that risk profiling could work for podiatry.

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

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  
☐ No  
☐ Not sure

Comment:
A more collaborative approach with the sharing of functions where they are the same.

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:
   Maintain profession specific Boards as in the AHPRA model.

24. What is the ideal size of RA boards?
   Comment:
   The Board would not want to see a reduction in Board sizes as workloads can be high for members. A range of 7 to 11 members seems reasonable, especially if there is greater use of a shared secretariat.

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

Other issues the Board notes are:

- Protection of title
- Enforcement needs tightening
- Anomalies around the ability/ inability to use the name of the profession when registered but without a current APC.
- Some parts of the invasive nature of podiatry should be added to the restricted activities list
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) Dr Flora Gilkison

Address: (street/box number) PO Box 5545 Lambton Quay
(town/city) Wellington 6145

Email: flora@nzoa.org.nz

Organisation (if applicable): New Zealand Orthopaedic Association

Position (if applicable): Chief Executive

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 HPC Act improve this?

Comment:

The initial comment is that the legislation must clearly define what the terminology used means. “Best outcomes for patients” is a desire which must be moderated by available resources and technology uptake. While “integrated care” can mean different things to different sectors and it must be clearly defined.

The HPC Bill in 2000 stated under defining Scopes of Practice that “the principal aim of scopes of practice is to provide a transparent framework so that health professionals and consumers of health and disability services can easily know the parameters a health professional is competent to work within and can be assured of their competence.” This statement is still just as valid today. The 2012 review that this submission is responding to refers to a future focus of “achieving the best outcomes for patients through integrated care” which then goes on at a later stage to raise the issue of “one of the original policy intentions was to encourage greater inter-professional collaboration and increased workforce flexibility”

Has this been achieved?

No and for a variety of reasons. The DHB environment has concentrated resources into the 20 DHBs with the MOH retaining control over large areas of funding and only slowly releasing these over the last ten years.

Has this contributed to “greater inter-professional collaboration and increased workforce flexibility”? The answer must be no. This is not just a DHB /MOH management issue the complexity of the health environment has changed considerably. There is now:
• more information available to both clinician and consumer
• huge increases in technology enabling increased testing and imaging to give a more accurate health picture for the clinician and patient and
• a groundswell of ‘worried well’ encouraged by growth of the internet and marketers on how to keep yourself healthy, what products to use and what tests must be done.

No one clinician can know all about everything and the complexity of the environment is only growing on a daily basis.

The question states:

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?

There is no definition of integrated care, is this functional integration (the key to which is financial management, human resources, strategic planning, IT platforms, marketing and quality improvement integration where common policies and practices by each of these functions integrate with each other. Note this is not to be confused with centralization or standardization) Or does integration mean Medical Practitioner Integration (the key to which is the extent to which Medical Practitioners are economically linked to a system, use its facilities and services and actively participate in planning management and governance.) In New Zealand we have two sets of Medical Practitioner integration – DHBs and PHOs; however there is not true integration between these two.

A third definition of integration is clinical integration (the key to which is an umbrella concept including the notion of continuity of care, coordination of care, disease management, good communication among caregivers, smooth transfer of information and records, elimination of duplicate testing and procedures and in general making sure things do not fall between the cracks).

If the HPC Act is to improve integration then it needs to define what it means by integration. Or the consequence is that a DHB manager interprets it as functional integration, a Medical Doctor as Medical Practitioner integration and a District Nurse just gets frustrated as they think clinical integration is what is required but it just doesn’t occur.

The answer to the question then is that the HPC Act needs to define what is meant by “best outcomes for patients” and “integrated care” to ensure a common understanding is held.

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 HPC Bill in 2000 stated under defining Scopes of Practice that “the principal aim of scopes of practice is to provide a transparent framework so that health professionals and consumers of health and disability services can easily know the parameters a health professional is competent to work within and can be assured of their competence.” This statement is still just as valid today. While the 2012 review
that this submission is responding to refers to a future focus of “achieving the best outcomes for patients through integrated care” which then goes on at a later stage to suggest that “one of the original policy intentions was to encourage greater inter-professional collaboration and increased workforce flexibility”. This is not necessarily the case and is a retrospective interpretation.

The HPC Act could provide a more flexible workforce by ensuring good consultation on changing different clinical roles and alignment of different scopes of practise which stays true to the principal aim of scopes of practice. This will provide a transparent framework so that health professional and consumers of health and disability services can easily know the parameters a health professional is competent to work within and can be assured of their competence. The driving factor must be that the legislation determines a framework whereby every health professional is competent, professional and their performance is appropriate for their scope of practices. The word professional must be used within its formal definition and not be allowed to have a casual dilution of interpretation through ignorance of its meaning and associated attributes. While superficially promotion of “a more flexible workforce” may seem to be a way of gaining greater productivity from current resources the unintended consequences are major with the likely effect of a more flexible workforce but one that is no longer held in high regard by patients as they are no longer confident or accepted scopes of practise. Note that due to the personal and confidential nature of many professional services, and thus the necessity to place a great deal of trust in them, most professionals are subject to strict codes of conduct enshrining rigorous ethical obligations. A desire for a more flexible workforce must not as an unintended consequence destroy what is the very nature of being professional, which is trust, rigorous ethics and moral standards of care.

By taking cognisance of the above concerns task substitution from a small group of highly skilled and specialised workforce may be able to be enlarged to incorporate a wider workforce, where the public knows exactly what scope of practise that worker is trained for and qualified to do. There is mention in the 2012 Review that the” HPC Act will provide an enabling environment in which RA’s can increase the amount of commonality and standardisation across professional groups. The Act allows them to identify more generic skill sets that can help build better multidisciplinary teams, support expanded or diversified roles and help simplify the process of health practitioners moving across to other workforce roles”.

If scopes of practice are to be extended then it must be within professional groups not across- OR a complete new form of workforce becomes envisaged. This is large structural change not evolutionary change. The Association is not anti-structural change but it must be well planned and communicated with appropriate grand parenting stages. To try to do this in the way the Review of the Act is suggesting will only cause confusion for patients and stakeholders. Remember it takes about 15 years to train an orthopaedic surgeon from the time of first entering university, so the change process will take a long time.
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:

An Act sets out a legislative expectation, it is then up to the agencies and stakeholders who use the Act to interpret it appropriately. The Act should say what is to be done and the interpretation by the users is to say how it will be done.

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:

Again the Act should stipulate standards expected, and the users of the Act interpret how best this is achieved. Again the Association goes back to requesting that the Act correctly defines what is meant by focusing on “achieving the best outcomes for patients through integrated care”. Integrated care does not mean centralization or standardization it has been proved time and time again that standardization does not give consumer choice and increased timely access to health services. “best outcomes” for patients is a desire which must be moderated by available resources, uptake of technology and accessibility to care. Grandiose statements of “best outcomes for patients” without adding the appropriate balancing statement regarding available resourcing is setting an expectation which is unaffordable and downright unfair to patients and their family, whanau.

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:
Finding the right balance means understanding what is the difference for patients and providers between needs and wants. Care must be taken to not put all the resources into appeasing a minority of vocal worried well while those living in poverty have neither the voice, the literacy, nor access to be able to be provided with information about their healthcare they require.

Broad scopes of practice will not improve this, education and utilising current resources appropriately will.

The challenge is sustainable health expenditure, without jeopardising access and quality of care. Couple this with:

- rapidly changing technology
- increased public access to information (not necessarily accurate)
- an ageing population
- a burgeoning youth unemployed segment
- calls for greater accountability from health providers and their associated systems
- unresearched variations in clinical practice and location of clinical practice

It seems to the Association a return to the old days of “broad scopes of practice” is no longer suited to modern day life. This is not where we should be going in the future and is not the panacea for the woes of a burgeoning costly health public health provision.

Patients want to know what their health practitioner is credentialed to do, as does the health practitioners peers. By having loose (this is really what flexible means) scopes of practice which cross natural boundaries will be just too hard to police and that is exactly one of the functions of the ACT. To provide a framework within which the public can feel safe, and by “setting qualifications that are the minimum requirements for public safety”.

You can’t have your cake and eat it as the tenor of this review seems to be suggesting.

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

Comment:
The Association’s members are registered with the New Zealand Medical Council RA, which does not have a pastoral care function as such but does have a Code of Conduct which members are required to follow. This is really all that a RA should be mandated to stipulate – A Code of Conduct. It would then be up to the RA how they wished to enforce the Code which may or may not involve an element of pastoral care. Pastoral care should be the responsibility of professional associations, Colleges and Societies and not the regulators.

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 covers how the public can be kept safe and be informed. Involving consumers appropriately in decision-making is required but the danger is that the pendulum swings too far and clinician experience becomes downgraded.

- Consumers want to have a greater choice of providers and to feel safe about using them, this includes complementary medicine.
- Consumers want reassurance that care is of a high quality.
- Consumers want to be able to decide between better technical care and interpersonal care and the location of these services.

The Act should make sure that sufficient boundaries are in place to inform and assure the public about health practitioners offering their services that they are suitably qualified, and practising in an appropriate manner. This does NOT mean that the Act should legislate for public forums, more that it should provide guidance to RA’s to “involve consumers appropriately in decision-making”.

The public needs to be better educated that no intervention is without risk. There seems to be a culture in New Zealand of high risk being accepted until a catastrophe occurs. A better educated public would have a better understanding of risks and their associated outcomes. The current Act provides sufficient means for the public to be informed. RA’s and professionals could provide more information to the public but this would mean the media taking on a more informative role rather than the current culture of either “amazing” or “shocking”.

The current Act as it stands does provide a sufficient framework and does not need changing in this area.
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:

As far as the New Zealand Medical Council goes the answer is yes. The Medical Council overall does a good job. Maybe the complaints process outcomes are not as widely publicised as could be but this is a RA role not a legislative role. Cannot comment on the other RA’s

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

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

Comment:

Care must be taken to not have too many lay people on RA boards. While they may (not always) be able to present the consumers point of view without adequate specialist knowledge their usefulness is limited. The Association is NOT advocating having no lay people the view is that the current mix is appropriate and does not need to be changed. The philosophy remains that the profession should regulate the profession.

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 Health and Disability Commission is the consumer forum. Should they wish to broaden their scope then that would be appropriate. There is enough opportunity to communicate with RA’s presently. The concern with an Act legislating on consumer forums is that the people whose voice should be heard will not be. The ‘vocal worried well’ will be the main advocates at any consumer forum, not those in poverty, their voice will remain unheard. Each RA could be legislated to ensure it consults with a broad spectrum of users, but that is as far as it should go.
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:
   The Health and Disability Commissioner, DHB complaints audits, ethics committees, RA’s codes of conduct are all part of current legislation. There is NO NEED to add more. In fact currently there are too many avenues for complaint and investigation, one rational body would be sufficient.

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:
   No, at the end of the day the legislation should be the guiding Act. Employers cannot be relied upon to regulate without appropriate guidance.

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:
   There is sufficient legislation. How the current legislation is interpreted brings the gaps. This is human nature and by closing one gap just opens another gap. The answer is to ensure legislation is more carefully drafted.

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

Comment:

By peer review, sole practitioners should/must be required by their RA to be involved in regular peer review, including audits of complications, and audited continuing professional development which includes a credential requirement.

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 RA should ensure risk mitigation through requirements that practitioners are involved in regular peer review, audit of complications, and audited continuing professional development which includes a credential requirement. One of the concerns here is how the groups are assessed as “risky” and how this would be applied. If this translates to high risk groups paying higher indemnity fees then the way medicine is practiced will change for the worse. The NSW near catastrophe with indemnity fees being so high that practitioners were not able to afford to practise in rural and deprived areas meant a change in legislation was required. The legislation if changed would need to be worded so that “good intentions” do not have unintended consequences which affects patients ability to access care.

Cost effectiveness focus

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

Comment:

Health costs need to be constrained, if RA’s set up a compliance regime that is too costly then health practitioners will be forced to pass these costs onto their patients who may then not be able to afford to access appropriate health care. . There is always a balance required, after all, in the end it is members of the public who pay the cost of healthcare either directly or indirectly as a taxpayer.
18. Should the HPCA Act define harm or serious harm?

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

Comment:

The HPCA Act should stipulate that each RA appropriately defines harm or serious harm and that these are included in the associated Codes of Conduct. It should be noted that definitions of harm and risk may be different for individuals, RAs, practitioners and Society.

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?

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

Comment: The Act must be clear as to what constitutes a “risk”. Otherwise interpretations of risk, creeps to encompass a wider range that is not necessarily appropriate and confuses the public.

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?

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

Comment:

Some would say it is either too much or too slow. When the risk of harm exists then the RA should be empowered to ensure it does not occur. The regulatory bodies need to have mechanisms whereby they can quickly assess complaints and deal with them at a lower level than “formal” investigations that create a great deal of stress for the practitioner.

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

- [x] Yes
- [ ] No
Not sure
Comment:
There is always room for improvement. The New Zealand Medical Council does review the way they manage their statutory functions and this is appropriate and should be a requirement for all RA’s.

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

☐ Yes
√ ☐ No
☐ Not sure
Comment:
RA’s are already enabled to consult widely, however consultation should be a two way process not just the RA telling other bodies what it is doing. A clear definition of consultation should be detailed in the legislation to ensure RA’s can be held accountable for their consultation processes.

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

☐ Yes
√ ☐ No
☐ Not sure
Comment:
There could be an alignment of some of the RAs; this would mean greater consistency across the spectrum. Sixteen seems a large amount for a small country and perhaps 10 would be more appropriate. Perhaps the major ones are Medical Practitioners and Nursing Council. Some of the others could be amalgamated, both at governance and secretarial level. This may be controversial as many smaller groups want to be independent. However with a desire for a more flexible workforce as a major driver for HPC Act change then better oversight over RA’s is required and this may mean decreasing the numbers.

24. What is the ideal size of RA boards?
Comment:
Nine to eleven. Within reason smaller boards are shown by research to be more effective.
25. Are there other issues you would like to raise?
   Comment:

New Zealand Medical Association Submission

NZMA
NZMA House
26 The Terrace
PO Box 156
Wellington

Phone: 04 472 4741
Facsimile: 04 471 0838

lesley@nzma.org.nz
2012 Review of the Health Practitioners Competence Assurance Act 2003

"In a well-arranged community a citizen should feel that he can at any time command the services of a man who has received fair training in the science and art of medicine, into whose hands he may commit with safety the lives of those near and dear to him.”

William Osler 1885

1. Introduction

About the NZMA
The New Zealand Medical Association (NZMA) is New Zealand’s largest medical organisation and has a pan professional membership. We have more than 5,000 members who come from all areas of medicine including medical students, resident medical officers, general practitioners, and other specialists.

The NZMA aims to provide leadership of the medical profession, and promote:
- professional unity and values, and
- the health of all New Zealanders.

The key roles of the NZMA are to:
- provide advocacy on behalf of doctors and their patients
- provide support and services to members and their practices
- publish and maintain the Code of Ethics for the profession
- publish the New Zealand Medical Journal.

Patient safety and quality of care is dependent on a system that ensures the development and application of standards for the health profession, its education, training, registration and practice. The medical profession understands this and demands excellence of itself and those that join it.

Professional Regulation
The NZMA continues to strongly support the concept and principle of professional self-regulation where reliance is placed on the internal morality of professional groups to govern themselves within an overall statutory framework. Although the concept of professional self-regulation continues to evolve, particularly in respect of improved transparency, greater involvement of lay people and broader accountabilities, it remains the cornerstone of professionalism and therefore the key to safe and effective health services for New Zealand. In the words of sociologist William Sullivan, neither economic incentives, nor technology, nor administrative control has proved an effective surrogate to a commitment to integrity evoked in the ideal of professionalism.

---

Professionalism itself is defined as the mastery of a complex body of knowledge, hand in hand with an ethical commitment to integrity, morality and altruism. These skills and attitudes are used in the service of others as the basis of a social contract between the medical profession and the community. Society in return grants the profession the privilege and the responsibility of self-regulation and autonomy in practice.

The World Medical Association has also stated in its Declaration on Professionally-led Regulation\(^3\) that as a corollary to the right of professional autonomy and clinical independence, the medical profession has a continuing responsibility to be self-regulating. The NZMA is therefore strongly of the view that required standards of patient safety and quality of care can only be achieved through the autonomous process of registration and competence assurance by independent bodies that involve the highest level of professional expertise and input, free from political and bureaucratic interference.

Any erosion of the independence of regulatory bodies or moves to further diminish the professional leadership of these bodies will potentially remove a key enabler and motivator for professionalism, in turn weakening the social contract that currently exists.

The NZMA acknowledges that the privilege of self-regulation rests in public trust and confidence and to retain this privilege the profession must deal appropriately and transparently with its members who do not perform to an acceptable standard and that the profession collectively must continue to fulfil its duty of public service. The role of the statutory framework for professional regulation in the health sector must therefore be to establish conditions where that trust can be maintained and professionally-led regulation operates rigorously, openly and consistently.

**Context of Review**

The NZMA notes that the 2009 report\(^4\) on the operation of the Health Practitioners Competence Assurance (HPCA) Act 2003 recommended that a review of the underlying policy settings of the HPCA Act is undertaken in 2012.

A review of policy settings relating to professional regulation is not a small matter and is one that potentially has major impact on the livelihood and practice of every individual health practitioner as well as the performance of each of the professions and the entire health workforce in New Zealand.

The NZMA is therefore concerned about the relatively short timeframe offered to professional groupings and other stakeholders to consider and debate the policies and principles that determine the regulatory framework that we work within and are paramount for ensuring the safety of New Zealanders.

We also note that the document revisits a number of the operational issues canvassed during the 2008/09 review. Following extensive consultation 37 recommendations regarding legislative and operational matters, including better information for the public, collaboration and cost containment, and key performance indicators were made at that


\(^4\) Review of the Health Practitioners Competence Assurance Act 2003 – June 2009 Report to the Minister of Health by the Director-General of Health
time. It is disappointing that little progress on these proposed improvements have been made and as a result these matters are still on the table.

The NZMA also notes the work of the Cabinet Economic Growth and Infrastructure Committee in 2009\(^5\) which was charged with the task of indentifying inefficient and superfluous regulation that could be removed. In considering the HPCA Act the Committee considered matters relating to the process for registration of overseas trained practitioners, authorisation of scopes of practice, ministerial audit and time taken to process applications. Cost was not raised as a matter of concern by the Committee who ultimately recommended that no immediate regulatory reform was necessary and deferred any wider policy review for the planned 2012 review “when more evidence of concerns may be available”.

Unfortunately the 2012 review has commenced with a complete absence of evidence of concern, despite the lengthy time since possible areas for examination had been identified. We are very concerned that unsubstantiated statements of failings and flaws in the statutory framework and its operations are being made without any evidence being provided or any consideration of the use of existing provisions of ministerial audit to review and address these matters as they arise.

In addition to the absence of evidence relating to the concerns raised in the discussion document, there is also a complete absence of evidence that a move away from the current regulatory model would achieve improvements and no detail of what could be changed legislatively and why, and what outcomes would be expected if those changes were made.

In summary therefore, the case for change has not been made and, as the HPCA Act is currently achieving its purpose, the rationale for a major shift in policy does not exist.

2. Discussion Document – policy settings

Workforce delivery
Of the matters raised in the consultation document a key policy issue centres on the influence of regulatory settings on workforce responsiveness.

To consider this matter a determination must first be made as to the primary role of regulation of health professions and therefore the purpose of the Act.

The stated 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 practice in their professions”.

These mechanisms include the determination of who is permitted to be a registered member of a health profession; ensuring that those who are registered are practicing competently and safely, and allowing the removal or limitation of practice of those who are found to be unfit to continue to practice autonomously.

The NZMA endorses this central purpose which provides clarity of function and does not, as stated in the introduction to the discussion document, require a balancing of competing priorities. Indeed, the implied proposition in the discussion document that the Act should also be a tool to respond to workforce priorities or influence workforce directions would inevitably create conflicting priorities for Responsible Authorities (RAs) that do not exist at this time. It is not the role of the HPCA Act to deliver the workforce but rather to ensure, and provide public confidence, that the workforce that is delivered is safe and competent.

Incorporating professional regulation as a component of workforce strategy is a major move away from the clear purpose of the HPCA Act. Such a move would entail adjustment of standards and decision making as priorities move with changing political directions and labour market pressures. Loosening or tightening professional regulation in response to these external influences in this way would damage the integrity of the regulatory function and turn what is essentially regulation of the individual for public protection into a mechanism to manage the workforce.

This would have the ultimate effect of creating a system that is not ‘fit for purpose’ as the core purpose of public protection is eroded due to conflicting objectives. It would also diminish the standing of New Zealand health practitioners internationally and the relative standing of the New Zealand health system. We have come a long way since the *Lancet* referred to New Zealand as “a happy home for every kind of unfeathered quack” and we must strive to ensure that we maintain our standards and good reputation.

**Standards for entry**
Concerns relating to the possible anticompetitive behaviour of the professions are also raised in the discussion document with the statement made that standards must be set at the level required to ensure public safety, and not at a higher level that provides more economic benefits to the health profession than is warranted.

Given that New Zealand has a high dependency on overseas doctors it is vital that we require these doctors to meet the same standards as those trained here and ensure they are to function safely and effectively in the New Zealand environment. This is critical in maintaining public confidence in the profession and considerations must go beyond simple examination of existing clinical qualifications.

The fact that 43% of our current medical workforce did not train in New Zealand, and we have doctors practising in New Zealand from many different countries, would suggest that the current standards are not a significant barrier to overseas trained doctors.

Section 13 of the HPCA Act states that the qualifications prescribed by RAs must be necessary to protect members of the public and must not unnecessarily restrict the registration of persons as health practitioners or impose undue costs on health practitioners or the public. Further, Section 124 of the Act allows the Minister audit RAs to ascertain whether the RA is complying with the provisions of the Act, including, without limitation the principles set out in Section 13.

---

*Lancet* 1897 (1):490
The NZMA is therefore of the view that there is adequate provision in the Act to ensure that entry requirements are appropriately set for safety requirements. If there are concerns that this is not the case or that anticompetitive activity is taking place the RA in question can be independently audited. The NZMA is unaware of any such audits being initiated in the almost 10 years since the Act came into force and if there is evidence that these issues exist we would suggest that the first course of action be to use these existing provisions rather than consider regulatory changes to address a hypothetical concern.

**Workforce flexibility**

It is also suggested that the current legislation and the way it has been operationalised has resulted in workforce inflexibility that is detrimental to establishing multidisciplinary teams and is hindering the drive towards improved integration in the sector. This relates to a view that some scopes of practice are too narrow to allow role extension and that there are difficulties encountered when extended scopes overlap with the existing scopes of other professional groups.

The HPCA Act does not prescribe scopes of practice, it simply requires that scopes are defined and that the RAs ensure that individual practitioners are competent to practice within their scope. The Act provides mechanisms (sections 127 and 128) to resolve disputes between RAs regarding overlapping scopes of practice and allows the Minister to intervene and ultimately give direction via an appointed expert panel.

As with standards of entry, above, the NZMA is unaware of any cases where dispute resolution provisions have been formally employed and there have been no instances of Ministerial intervention in the decade the legislation has been in operation. Scopes of practice have evolved significantly for many professions over this time and will continue to do so as new models of care and workforce innovations are developed.

The discussion document does not elaborate with examples or scenarios of workforce problems resulting from scopes of practice, or the legislative requirements of the HPCA Act generally. Again, the NZMA is therefore of the view that there is already adequate provision in the Act to address such issues if they arise.

We would also comment that effective team work cannot be legislated for. Effective teams work in a culture of trust and respect. Doctors possess the ability to work as members of healthcare teams, recognising and respecting the skills and attributes of other practitioners. Clarity of roles and scopes of practice therefore serve to enhance teamwork rather than detract from it. Conversely uncertainty regarding role and scope could cause tensions within the team and potentially create risk for the patient and the professionals involved.

The NZMA understands that the Council of Medical Colleges (CMC) has suggested that existing requirements under the HDC Code of Patient Rights and codes of ethical conduct regarding co-operation and communication among providers could be reflected in the HPCA Act, perhaps via an explicit addition to the Section 118(j) requirement of RAs to liaise with each other on matters of common interest. The NZMA would support further exploration of this option.

---

7 Consensus Statement on the Role of the Doctor in New Zealand – NZMJ 4 November 2011, Vol 124 No 1345
Value of statutory regulation

The executive summary of the discussion document states, under the heading of ‘safety focus’, that it is necessary to consider whether there is an appropriate balance between the safety concerns of employers and the requirements of government regulation. As an example the question is asked “if employers already have all of the systems in place for groups of health professionals to keep the public safe from harm, what additional value does statutory regulation have in this situation?”

This proposition confuses the need to regulate individual practitioners, regardless of employment status and practice setting, with the need for employers to operate whole-of-business quality management systems. It also appears to suggest that health practitioners who are salaried could be exempt from professional regulation which would give rise to a number of issues.

The main flaws in the argument that employer based safety provisions are sufficient and could replace professional regulation are:

- Even large employers such as DHBs would struggle to assess entry requirements and ongoing competency of any single professional group yet alone the multiple professional groups that are employed across the organisation.
- A dual system would need to continue to regulate those professionals who are self-employed, in independent practice, or employed by smaller organisations such as private clinics and hospitals, community pharmacies, rest homes etc.
- Conflicts would be a significant risk as employers juggle operational needs with quality and safety.
- The relative standing of New Zealand’s health professions would be diminished internationally.
- The principle of professionally-led regulation would be lost.
- A consistent accountability regime for all health professionals would cease to exist.
- Variation across employers would arise as we have already seen with credentialing processes.

The NZMA is also of the view that DHBs have a poor track record of dealing with professional accountability. This is evidenced in a recent Section 95 Inquiry\(^8\) into mental health services delivered by Hutt Valley DHB. The inquiry found serious failures at managerial levels that had significant bearing on the patient incidents involved. A clinician was held accountable for apparent failure in care and was referred by the Director of Mental Health\(^9\) to the Medical Council for investigation and possibly disciplinary action. However those managers who were found to have made poor

---

\(^8\) Findings of an Inquiry Under Section 95 of the Mental Health (Compulsory Assessment and Treatment) Act 1992: An inquiry into Hutt Valley District Health Board Mental Health Service including the clinical management of certain patients and the operation of the Office of the Director of Area Mental Health Services 26 January 2012.

decisions or failed to take action to address the situation have not been held individually accountable.

The NZMA acknowledges that other quality and safety mechanisms exist in the health sector and that these continue to evolve, helping to enhance safety and health outcomes for patients and the standard of health services generally. We do not believe however that quality assurance through these mechanisms, which are generally at a systems level, will ever be a surrogate for direct regulation of the individual.

Level of Risk
The section on ‘safety’ in the discussion document also asks whether the HPCA Act is clear about the level of risk that needs to be regulated by statute.

The HPCA Act refers to the provision of mechanisms for protecting the public from health practitioners who practise below the required standard of competence or who are unable to perform the required functions of the role. Certain activities can be restricted to particular health practitioners where the Minister is satisfied that members of the public risk serious or permanent harm if the activity is performed by persons other than health practitioners who are permitted by their scopes of practice to perform that activity. The likely risk of harm is also a deciding factor as to whether other, currently unregulated, health services are designated health professions and brought in under the Act.

While ‘risk of harm’ is not defined under the Act the Medical Council has developed the following criteria:

Risk of harm may be indicated by:
- a pattern of practice over a period of time that suggests the doctor's practice of medicine may not meet the required standard of competence; or
- a single incident that demonstrates a significant departure from accepted standards of medical practice; or
- recognised poor performance where local interventions have failed - this does not exclude notification of serious concerns where internal review or audit is inaccessible or unavailable to the person with the concern; or criminal offending; or
- professional isolation with declining standards that become apparent.

Risk of serious harm may be indicated when:
- an individual patient may be seriously harmed by the doctor; or
- the doctor may pose a continued threat to more than one patient and as such the harm is collectively considered ‘serious’; or
- there is sufficient evidence to suggest that the alleged criminal offending is of such a nature that the doctor poses a risk of serious harm to one or more members of the public.

The NZMA does not believe there is a need to define the level of risk that needs to be regulated by statute. There is sufficient scope within the HPCA Act to control the level of risk being regulated against, both in the principles set down in Section 13 and in the Minister’s ability to audit and be satisfied that regulation is required and that the nature or degree of regulation is commensurate to risk.
Attempting to further define the level of risk that needs to be regulated under the statute would limit the Minister’s consideration of these matters on a case by case basis, the flexibility that needs to exist within a rapidly changing sector and the ability of RAs to intervene.

3. Discussion Document – operational matters

As previously noted the 2008/09 review of the HPCA Act culminated in 37 recommendations for legislative and operational improvements. Of these 37 recommendations only 6 have been implemented in full while the remainder either require ongoing action, or are currently under consideration or awaiting legislative amendment.\textsuperscript{10}

If these matters had been progressed in a more timely fashion it is possible that some of the perceived shortcomings of the current system would have been mitigated. In particular the implementation of Recommendation 12 to develop a set of indicators to measure the effectiveness of the HPCA Act and the performance of RAs would have enabled a more informed review of the policy settings for professional regulation than this discussion document offers. Instead the Ministry’s response as to what progress has been made to date in relation to Recommendation 12 was that developing a set of indicators was considered during the development of the common reporting template for RA annual reports but no further action has been taken since then.

Cost of regulation

No analysis of costs has been provided in the discussion document nor any attempt made to assess costs verses benefits. A statement is however made that the type of statutory regulation currently in the HPCA Act is considered an expensive way to ensure the public are safe from harm when accessing services but this is unsubstantiated and no comparators showing cost differentials are provided.

While the NZMA acknowledges that compliance with the HPCA Act involves both direct and indirect workforce and health system costs it is impossible to judge value for money in the absence of information and analysis. We agree however that RAs must consider cost impact on individuals, employers and ultimately consumers and tax payers when considering scope of activities and resourcing requirements (RAs work on a cost recovery basis). This consideration must however be balanced against ensuring that standards are maintained, processes are fair and comprehensive and that public safety and confidence is assured.

While the question of whether we can afford to maintain a robustly regulated workforce is valid it is equally valid to ask whether we can afford not to. In the case of the medical profession we believe that regulation is being administered under the principle that the practice of a profession will only be restricted where benefits of restriction outweigh the costs.

\textsuperscript{10} Information released under the Official Information Act 1982 by the Ministry of Health to the New Zealand Medical Council September 2012.
The NZMA is aware that work is underway to seek efficiencies and cost saving through the sharing of RA secretariat and office functions. While it is appropriate to consider ways of reducing costs in this way it is imperative that any changes to existing RA structures do not in any way diminish the capacity of each RA to regulate its professional group and ensure public health and safety.

As noted previously, regulatory processes affect the livelihood and practice of every health practitioner. It is therefore critical that registration bodies are responsive to individual registrant’s needs and circumstance. Services are best delivered by those with intimate knowledge of the profession they are working with and who can relate to and understand the particular needs of that health professional group.

The NZMA outlined its concerns regarding this proposal in our submission to Health Workforce New Zealand dated 11 April 2011 and our support remains limited to options of streamlining back-office functions where there is a clear demarcation between generic administration functions and regulatory activities.

**Data collection**
The NZMA agrees that workforce data is essential for workforce analysis and planning and we support RA collected data being made available for this purpose. Issues of privacy can be dealt with by the provision of only non-identifiable data and matters of common definitions and standardisation should be able to be resolved.

Improved data collection and reporting into a centralised repository may however require initial investment and an ongoing increase in costs for some RAs which may increase fees if not directly funded. These costs therefore need to balanced against the benefits of data collection in the same way that it is suggested that regulation be weighed against costs more generally.

**Consumer involvement**
The primary interest consumers have in professional regulation relates to safety so that they can have confidence that those providing health services are appropriately qualified and are competent in their area of practice. Consumers also want to be assured that action is taken to address individuals whose practice is below standard and if necessary their practice is curtailed.

Improving public understanding of the HPCA Act is challenging as often there is little desire to seek out this information until something untoward happens within the health professional / patient relationship. Consumers will otherwise assume that both the professions and the government will have the appropriate checks and measures in place.

The NZMA believes further improvements to public understanding of health professional regulation in New Zealand could be achieved alongside improved health literacy generally. This would be best coordinated nationally by the Ministry of Health and would require ongoing investment in educational and social marketing strategies.

The concept of a consumer forum in New Zealand that would provide a platform for consumer input is something that should be explored. Ideally this would not be limited to this particular area and could facilitate consumer involvement across the health sector as
has been the experience across the Tasman with the establishment and successful operation of the Community Health Forum of Australia.

The discussion document also asks whether we have the balance of laypeople and health professionals on RA boards. While this is an important question we would however caution against confusing lay representation with consumer input. Lay appointees to boards will of course bring their own perspectives as consumers to the table, hopefully along with governance skills and experience. These individuals may not however be representative of consumer views and therefore the need for other avenues of consumer input remain.

While the presence of lay appointees to RA boards and councils is fully supported, the NZMA believes that RAs need to remain professionally-led as per our opening statement in this submission. As such we endorse the Medical Council structure of four laypersons, four doctors elected by the profession and four doctors appointed by the Minister of Health.

**Pastoral care**

It is a function of RA to consider the cases of health practitioners who may be unable to perform the functions required for the practice of the profession. This may ultimately mean a determination to restrict practice or suspend or cancel registration.

Mixing this core role with a requirement for RAs to provide care for health professionals as is suggested in the discussion document is challenging and could be counterproductive. On one hand patient safety may be compromised as the RA attempt to work with the health professional to identify and resolve the matters affecting practice and on the other hand knowing that the entity that provides pastoral care also has the ability to remove you from practice could be a barrier to seeking support.

The Medical Council does provide support services to health professionals needing assistance but in managing the “unwell doctor” the Council’s Health Committee will typically impose restrictions and/or requirements and as a consequence under-reporting does exist.

In order to fulfil their primary purpose RAs will always need to protect public safety first and care for the doctor second. As such it would be better to separate the roles of legal enforcement and pastoral care.

The NZMA is currently developing a position statement on doctors’ health, wellbeing and vitality and would support the establishment of an independent service that is professionally run and appropriately resourced providing support for health professionals. This could operate on a confidential basis to encourage self reporting but with the requirement to report to the appropriate RA any individuals whose practice is sufficiently impaired to constitute risk to patients. The NZMA also suggests that workforce wellness and wellbeing be acknowledged as a quality indicator for health services generally and a performance measure for DHBs.
Regulatory options
The NZMA supports the principle of regulation commensurate with risk. When considering which professions should come under the auspices of the HPCA Act, those who could be regulated using an alternative model, and those who do not require statutory regulation, assessment of risk must be the primary factor.

To this end, Section 116 of the HPCA Act allows the Minister to make a determination in the regard based on the risk of harm to the public or matters otherwise in the public interest.

We share Government’s concerns about the increasing number of health provider groups seeking to be recognised as a profession and regulated under the HPCA Act and the potential proliferation of RAs being created for these new groups. The NZMA is also concerned regulation under the same statute that regulates doctors can serve to give these practitioners, their methods of treatment and the products they use, legitimacy and credence that they otherwise would not have had.

The NZMA has previously suggested of a two tier system of regulation, the first being the current system to cover those professions where there is potential for significant harm and the second being a lesser licensing system that covered those professions where there was the potential for some harm but at a lower level. This would provide a mechanism to regulate where there is some risk of harm but in a way that does not add significantly to the overall cost of regulation and avoids undue standing being conferred.
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: Gillian Gonthier

Address: Private Bag 2016
          New Plymouth

Email: Gillian.gonthier@tdhb.org.nz

Organisation (if applicable): Taranaki District Health Board

Position (if applicable): Advisory Dietitian

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):

Clinical Workers ...........................................

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

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:

Upskill & improve training & registration of professions currently unregistered. Also consider groups with no formal training, such as naturopaths, who currently profit from selling products and who do not bear the consequences of a perceived lack of duty of care. Because the customer is buying a product they may be subject to 'user beware' but are not in a position to make this judgement.

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

Comment:

Do not think that this is appropriate or the intent of the Act
It is process orientated
Problems can occur when practitioners work outside their scope of practice with no supervision.

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?
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:

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:

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

☑ Yes
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:

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:

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

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
- [x] 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
- [ ] Not sure
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:

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:
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:

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

☐ Yes
☐ No
☐ Not sure

Comment:
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:

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
☐ No
☐ Not sure

Comment:
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:
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: (name) withheld

Address: (street/box number)

(town/city)

Email:

Organisation (if applicable): Physiotherapy New Zealand

Position (if applicable):

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
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:

Increased integration of the health workforce needs to come from a solid professional basis. Integrated care was never the role of the HPCA Act consequently making changes to the Act will not improve integrated care. Over the past 10 years team work amongst health professionals has improved in response to changing population health needs.

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

Comment:

What evidence is there that the current workforce is not flexible? Overlaps in scopes of practice as defined by the different RA’s are already present and working well under the current Act, and there is the ability for professions to be more flexible without making changes to 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
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:

The Code of Health and Disability Services Consumers’ Rights is the background document for the codes and ethics developed by each profession. Individual professions have developed codes and ethics to give greater guidance and protection to the public in the specific areas of concern for that profession. A generalised code would not achieve this. Some common learning modules could be developed based on the Code of Health and Disability Services Consumers’ Rights and delivered through the Regional Training Hubs.

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

*☐ Yes
☐ No
☐ Not sure

Comment:

Broad scopes of practice such as exist for physiotherapy allow for flexibility in service delivery and collaboration, and support the work of interdisciplinary teams. The scope already overlaps with Nursing, Occupational Therapy and in some instances the Medical profession.
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:

No – this role sits with the professional organisations.

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:

Although most of the public is probably unaware of the HPCA Act its implementation by the Regulatory Authorities has helped improve public safety by putting in place on-going competency standards for health professionals. The public is only interested in outcomes and the complaints process and it is important they know how to access assistance if wanting to make a complaint.

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:

The release of information on complaints and the complaint process is more transparent since being regulated by the HPCA Act although there is still room for improvement.

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

☐ Yes
*☐ No
☐ Not sure

Comment:
It is important that all appointments to the RA’s are skills based and the appointees have a good understanding of their governance role, and laypeople are represented. In the previous review it had been suggested common training be provided for all new appointees. An independent Board for all the RA’s is costly and may not be necessary.

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:
A change in the Act is not needed for consumer surveys to be undertaken. These could be introduced as a KPI for the Regulatory Authorities. Consumer forums work well in the UK and Australia and are an important voice providing valuable input from a different perspective. For a consumer forum to be an effective voice it would need to be adequately funded by the Ministry of Health and one consumer forum should provide input into all the RA’s.

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
*☐ Not sure

Comment:
Statutory regulation under the HPCA Act provides the umbrella legislation for all health professionals. In big organisations e.g. DHBs there are strong employer-based risk management systems in place but this is often not the case in small private practices which make up the majority of the primary care health workforce. Statutory regulations provide protection for the public and small practices.

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:

One gap in the current structure is regulation of counsellors and this has been raised in the past. Some form of regulation of this group of healthcare providers should be in place as they often deal with upset and vulnerable people and the public needs confidence they are not seeing an unscrupulous provider.

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:

Firstly the concern should not be about sole practitioners but isolated practitioners. An isolated practitioner could be working alone but could also be part of a bigger organisation but does not engage.

The HPCA Act goes a long way towards decreasing this isolation. Various RA have introduced compulsory CPD hours, working in collegial relationships, regular peer review and supervision.

The whole section has a strong emphasis on the DHB sector where HR services are easy to access. The same level of support is often not available for independent community based providers.
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:
A risk profiling approach could have benefits. Small private practices providing services in the community may be of higher risk due to their lack of access to HR and other support services. Some professions may be at greater risk due to their more vulnerable caseload.

Cost effectiveness focus

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

Comment:
It is important the RAs consider the cost impacts of their decisions as the costs are eventually passed onto consumers. Some RA’s are doing tasks that sit more appropriately with the professional bodies. However the cost (which is sometimes covered by employers) of annual practicing certificates for regulated health professionals should never be used as an argument for employing non-regulated health workers. This totally undermines the intention of the HPCA Act which was to improve public safety.

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

Yes
No
Not sure

Comment:
Defining harm or serious harm could mean possible future incidents may not be covered. The Medical Council already provides guidance.

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:
Risk profiling should be undertaken by the Ministry of Health to determine what is ‘high level risk’.

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
   - [ ] No
   - [ ] Not sure
   Comment:
   It is important that duplication of processes is removed so there are more shared services, currently even with shared office space there is a lot of duplication of processes. More activities could be centralised. It is important the RA’s are accountable to the Government, Ministry of Health and the profession they represent, as well as to the public. There also needs to be a clear line between the role of the RA’s and professional bodies.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   * [ ] Yes
   - [ ] No
   - [ ] Not sure
   Comment:
   It is important the RAs are accountable and this may involve greater consultation with relevant stakeholders.

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

There are a lot of common shared processes and they do not need different regulatory boards to implement them. It is suggested a multi-tier system of regulation could be implemented to ensure health workers not already covered have a level of accountability monitored through a professional body by credentialing and accreditation standards.

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

The maximum should be reduced. If the number of Boards is reduced you may need one larger Board to ensure representation from the different professional groups with perhaps smaller (3-4 members) reference groups sitting below them but able to provide feedback.

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

The first recommendation from the 2009 review was: That it be noted the HPCA Act 2003 is currently operating largely as intended.

There is no reason to believe this is not still the case. The discussion document seems to assume that the HPCA Act is not working and therefore needs fixing. There is an assumption that regulation is stifling innovation and preventing team work as people are confined by their scope of practice. There is though no evidence to support these assumptions. The HPCA Act has succeeded in its major role of protecting the public and it is day to day implementation is through the Regulatory Authorities. Most of the issues raised in the document around better data collection, better workforce planning and implementation of inter-professional training modules through the Regional Training Hubs relate to the role of Health Workforce New Zealand.

In conclusion most of the points for discussion in this document can be achieved without legislative changes. The only issues that need changes to the Act relate to the structure of the RA’s and their level of accountability.
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](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: Vanessa Cumming (ADONZ)

Address: PO Box 137
Morrinsville 3340

Email: adonzpresident@gmail.com

Organisation (if applicable): Association Dispensing Opticians New Zealand

Position (if applicable): President & Executive

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
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 allowing delegated tasks under supervision that allow integrated patient care when they fall outside the scope of practice.
   
   IE: refraction: patient has just been seen by Ophthalmologist or Optometrist. By allowing a Dispensing Optician to complete the new refraction the optometrist’s time is better served by completing pathology which in turn frees up access for other patients for the correct and appropriate care.

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 encouraging and up-skilling educational programs that cater for Scope of Practice overlap.
   
   It would be prudent to look at ABDO (Association of British Dispensing Opticians) and how they have achieved a wider scope of practice. This is not forging new ground but is a beneficial system for all professionals involved.

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?
By promoting an integrated approach between Ophthalmologists, Optometrists and Dispensing Opticians for the best outcomes for patient care. This would allow a more flexible workforce.

IE: If a patient has just seen an Ophthalmologist for the final check and doesn’t require a second health check if only refraction is required, for example: post cataract surgery.

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:

All health care professionals should abide by the same code of conduct and ethics and common learning across the entire health care sector.

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:

We would encourage a simple form of public access to the required information of what they can expect from a health practitioner which relates to scope of practice.
6. Could/should RAs have a mandated role in health professionals' pastoral care? If so, how can they carry this out?

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

Comment:

---

**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:

---

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:

Easily found on the website, we don’t hear of many complaints but the process is certainly there to be followed if required.
9. Do we have the right balance of laypeople to health professionals on RA boards?
   - Yes
   - No
   - Not sure
   
   Comment:
   For us, as a shared RA Board between Optometrists and Dispensing Opticians we would recommend 2 lay people, 2 Optometrists & 2 Dispensing Opticians, removing 2 Optometrists, providing a balanced RA.

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:
    Absolutely there should be a public forum that feeds into the RA with matters of concern.

**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

☐ Not sure

Comment:

*Corporate employers may be included to put commercial decisions ahead of risk management*

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:

*In our profession we believe the legislation covers the required level of safety*

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:

By the continued endorsement of the existing act
IE: Continuing Professional Development

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:

We are unaware of any requirement of RA’s to consider the cost impact.

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

☐ Yes
☐ ☑ No
☐ Not sure
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:

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
- [ ] No
- [ ] Not sure

Comment:
As per our suggestion on RA balance
IE: RA Board structure: 2 Laypeople, 2 Optometrists & 2 Dispensing Opticians
Providing equality to both professions.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   ✔   Yes
   ❑   No
   ❑   Not sure
Comment:
Particularly if Scopes of Practice are extended and delegated tasks are considered.

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:
The size should reflect the Scope of the Health Care Provider
O&DO Board should provide an equal number of professionals, IE 2 Optometrists, 2 Dispensing Opticians and 2 Laypersons. Therefore there is no imbalance and no one profession pushing their own agenda or controlling another Professional Health Care Provider.

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

We would encourage the need for there to be a process that allows a Health Care Professional, or Association, to have access to a mediator if there is conflict with an RA.

If a RA is shared by two professions there should be equality, no one profession should outnumber the other profession. Particularly looking at the O&DO Board. 2 Optometrists, 2 Dispensing Opticians and 2 Laypersons. Providing equality to both Professional Health Care providers.

We would like to see a process put into place where we have the right to appeal a decision put into place by the RA. Where do we go if we believe the person doing an assessment on our education is not qualified to make the decision. Or the person assessing is biased. Etc.
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: Ben Gray & Eileen McKinlay

Address: 23A Mein Street

Email: ben.gray@otago.ac.nz eileen.mckinlay@otago.ac.nz

Organisation (if applicable): Otago University Wellington

Position (if applicable): Senior Lecturers Primary Health Care and General Practice

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

☒ individuals (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 ☐ Family/whānau
☐ Pacific ☐ District health board ☐ Māori
☐ 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:
1. It is important to define integrated care as it means different things to different people. We think it means care integrated across health sectors (primary/secondary) but also could include other professional services such as social services including NGOs, justice, education. Shared care is also a concept in common usage- it has a much stronger emphasis on patient involvement http://www.sharedcareplan.co.nz/ Should HPCA strengthen/support the role of patients within the integrated care model.

2. Team work is implicit in providing integrated care; this also needs to be defined.

3. We currently register individuals rather than teams, and this is for many circumstances entirely appropriate. Lingard (Lingard L. What we see and don’t see when we look at ‘competence’: notes on a god term. Adv Health Sci Educ Theory Pract. 2009;14(5):625-8.) makes the cogent point that “competent individual professionals can—and do, with some regularity—combine to create an incompetent team.”

4. A current barrier to integrated care is who should be the leader of the team and is the leader therefore professionally and/or legally liable for team decisions or action/inactions. Doctors currently tend to take leadership roles in teams but should not necessarily need to do so (distributed leadership may be better or different disciplines may be better to take on this role). Doctors often still feel accountable for decisions/actions made by the team. HDC decisions have not necessarily supported a distributed leadership model.

5. Where the balance is between the regulation of individuals and the regulation of workplaces would stand some scrutiny. The experience of general practice is relevant. For example it makes much more sense for the maintenance of the cold chain for vaccines to be a “practice” responsibility rather than an individual practitioner responsibility. This is an element of the “Cornerstone” practice accreditation programme. Currently Cornerstone is not mandatory and in fact there is little business benefit in having a practice accredited. If practice accreditation were mandatory then a number of elements of registration could be moved to the “team” in the practice rather than sitting with individuals. This is not currently a practical option as many practitioners would be in stand alone businesses. The question is whether this mode of practice is acceptable if we are trying to provide integrated care.

6. Should we have a Health Service Organisation Competence and Safety Assurance Act? This could bring together current regulation around hospitals, rest homes and expand it out to other providers. This would provide a place to ensure that the patient safety agenda is able to be implemented

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

Comment:
1. All health professionals need to learn to work effectively in teams. This requires considerable pedagogical skill and is best achieved by interprofessional education.

2. Common health professional competencies/understandings can be identified (ethics, cultural competence, consultation skills, communication, safety and risk, infection control etc) and then taught through interdisciplinary education beginning at undergraduate level.

3. Such programmes should be explicitly interprofessional – not multidisciplinary (ie Learning with, from and about each other http://www.caipe.org.uk/resources/). There are two HWNZ interprofessional pilots in progress and these models should be more widely disseminated. Elements of IPE should be mandatory across all undergraduate health professional programmes.

4. Ongoing education for all health professional should continue to have interprofessional as well as discipline specific competencies—there could be a requirement for RAs to see evidence of IPE learning.

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:
See above We particularly agree with the need to promote patient self management although this should be delivered within a wider Chronic Care Model (eg Wagner) as there are specific skills and responsibilities health professionals require to support self management (including communication, patient advocacy, shared care, shared electronic records etc). Health professionals also need to understand the impact of health literacy as one component of self management.

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:

See above. We agree - a stocktake of commonalities is required and that a standard base developed. We know commonalities exist and these need to be emphasised to enhance possibilities for effective teamwork. A shared curriculum around ethics, cultural competence, consultation skills, communication, safety and risk and infection control should be considered to progress this concept.

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:

1. We do not have sufficient knowledge of the detail of the scopes of the different RA's.
2. We would see the issue of scope of practice as intertwined with the curriculum for training for that scope but as above commonalities should be defined.
3. We are unsure what level of information the public require to assist their expectations of different health professionals (more work is needed here - consumer reps should be involved)
4. Detailed information is really only needed to ensure that particularly dangerous activities are carried out by people trained to do them.

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:

RA’s are too distant from the coal face to be effective at pastoral care.
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:

1. It is not possible to “keep the public safe” in an absolute sense, the level of safety depends on the level of expenditure, the tightness of regulation, and the quality of the systems within which the care is provided. The HPCA act cannot address all of these although it can contribute.

2. We are unsure if it is the responsibility of the HPCA to involve consumers in decision making, is this not a professional responsibility?

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:

1. We are ambivalent about this in that there is a poor correlation between complaints and competence. As Bismark found only 4% of serious medical misadventure episodes lodged with ACC were the subject of a complaint to HDC.

2. In our view HDC is a great complaints resolution organisation but has limited ability to do effective quality improvement because of this. It is most important that the health bureaucracy, employers etc have good access to relevant information.

3. One current limitation is the limited ability for health professionals to be able to report poor professional practice of other health professionals.

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

☐ Yes
☐ No
☒ Not sure
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:

1. We can see advantages in this if informed/trained consumers were included and were appointed to represent a constituency group.

2. We would be concerned about the extent to which such forums could be overly influenced by single issue groups. It is extraordinarily difficult to get a “consumer representative” who represents anything other than a very small portion of the public.

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 cannot “Keep the public safe from harm”. How much harm will depend on how much we spend, how much we try to do, how much we regulate etc. Regulation is a blunt tool to try to influence practice….the patient safety (HQSC) process has much more promise of building a culture of quality improvement, rather than setting rules that say that the public should not be harmed.

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

☒ Yes
☐ No
See above Quality and safety processes are very well developed in other business orientated organisations and health has a lot to learn from them (airline industry).

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:

There is a paradigm clash between the regulatory/disciplinary model of maintaining standards, and the systems approach quality improvement model of improving care. The former is individual focussed. Because a possible outcome is the loss of ability to work, the process has to focus on natural justice, is drawn out, and gets a seriously edited version of the “truth” of what happened. The latter process is likely to find more detail about the episode as people will not hold back information for fear of personal retribution. Lawyers are usually not involved. The focus is on how to make things better rather than finding out who to blame. The risk is that people who should be held accountable are not held accountable. We need to do more work on where the interface between the work of the HQSC and HDC is.

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:

Those that are regulated are regulated because of history, not because they are necessarily of greatest risk. The group that is not regulated that concerns us the most is interpreters. Without some external assurance of the training and ethical standards of an interpreter we cannot gain valid informed consent for a serious procedure from a patient with limited English proficiency. By comparison it is unclear to us why medical laboratory people create a risk that is sufficient to require regulation.
15. Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?

Comment:

1. Most health professionals especially those in higher risk professions should be discouraged from working in small practices, or if in small practices be networked with other practices to provide some of the organisational oversight that can manage these risks.

2. Peer review and professional supervision should be supported as best practice for all health professionals.

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:

Could be

Cost effectiveness focus

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

Comment:

1. There must be a balance between cost impact and cost benefit.

2. The risk is that RAs will be reactive to episodes when harm occurs…based on the public premise that the “public should be protected from harm” which is not always possible.
18. Should the HPCA Act define harm or serious harm?

☐ Yes
☐ No
☒ Not sure

Comment:

On the one hand it would be hard to reach a consensus on what would be considered serious harm across the RA’s so nothing practical would be gained by attempting to further define. The concept will always be applied to specific instances so discussing whether a particular situation constitutes “serious harm” is more useful.

On the other hand averting harm or serious harm is an expensive activity. The lower we set the bar as to what is “serious” the more it will cost, so the act should provide some guidance on this. A parallel could be drawn with research ethics. We could argue that the amount of harm that can ever occur from an observational study is so low that we should not require observational studies to apply for ethics approval. This would save a whole load of compliance costs. How much extra risk would there be? How bad would it be? Is it worth trying to stop that risk? Who decides? Our sense is that the ethics committees err on the side of worrying too much about low risk issues, but as a researcher we have no ability to debate that and just have to comply with the rules.

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:

Our example above about interpreters is an area which is not regulated but for which we believe there is significantly more risk than some of the professions that are regulated. We would be in favour of some graduation of regulation. Perhaps for some lower risk professions they could be registered on the basis of having completed appropriate training and remain registered after that unless they are struck off for unacceptable practice, with no requirement for continuing recertification.

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

☒ Yes
☐ No
☐ Not sure

Comment:

Strongly in favour of amalgamating the administrative functions. We believe there should be incentives for them to develop joint policies and competencies around issues such as ethics, cultural competence, consultation skills, communication, safety and risk, infection control etc.

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: Unsure

25. Are there other issues you would like to raise?
Comment:
We are interested in the linguistic differences between “Competence” “Fitness to practice” and “Safety”. They are all related but different and we don’t think that the act is coherent in how it addresses these concepts. Patient safety cannot be ensured by ensuring competence of individual practitioners. Competence sounds like something that you can measure when many of the attributes of concern are only able to be reliably detected when they go wrong. It is unclear what the relationship is between a single patient safety episode and the competence of the practitioner.
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) Andrew Duncan and Keith Tudor on behalf of Ingrid-Rose Nagl and Paul Solomon, Convenors, Nga Ao e Rua

Address: (street/box number) 7/33 Seaside Ave, Waterview, AK 1026 (town/city) Auckland

Email: andrew@donnache.co.nz

Organisation (if applicable): Nga Ao e Rua (representing a membership of 60 people)

Position (if applicable): Convenors

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): A bicultural group of psychotherapists, counsellors and health care providers

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?
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:
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:

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:

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:
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:

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:

Due to issues related to Te Tiriti (see final comments)

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:
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:

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
☐ Not sure

Comment:

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:

Te Tiriti is missing (see final comments).

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?
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:

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

☐ Yes
☐ No
☐ Not sure
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:

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
- No
- Not sure

Comment:
22. Should RAs be required to consult more broadly with relevant stakeholders?
   X Yes
   No
   Not sure
   Comment:
   
   Very poor consultation with Maori providers and Maori consumers by Psychotherapists Board.

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? Yes see below:
We are particularly concerned about the bicultural issues in the HPCA Act and in the review of the Act.

1. **The original Act made no reference to Te Tiriti o Waitangi | The Treaty of Waitangi**

At the time the then *Health Practitioners Competence Assurance [HPCA] Bill* was in progress through Parliament, this omission of Te Tiriti | the Treaty was justified by the Ministry of Health (MoH) (2003) in a three page statement in which it asserted that:

The Treaty of Waitangi provisions in the NZPHD [New Zealand Public Health and Disability] Act [2000] convey what the Crown, itself and through its DHBs, have done, is doing, and will do under the Treaty for Maori health.

The HPCA Bill establishes a regime for the registration and discipline of health practitioners. No additional or new Treaty interests are put in issue under the HPCA Bill. (p. 2) We do not accept this. The registration of health practitioners and the wide-ranging powers of “responsible authorities” under the *Act*, including their powers to extend scopes of practice, has huge implications for indigenous practitioners. Furthermore it is clear that the failure to prioritise Treaty issues contributes to the poor health outcomes for Maori.

The assertion by the MoH was based on Crown Law advice and on a Waitangi Tribunal (2001) finding in the Napier Hospital claim that the *NZPHD Act 2000* makes adequate provision for Crown Treaty responsibilities in the health sector. This is a sweeping statement with far-reaching consequences; is debatable; and, with reference to psychotherapy, is a claim which must be measured against the experience to date of the failure of the Psychotherapy Board of Aotearoa New Zealand (PBANZ) to engage adequately with the profession or with Māori practitioners.

2. **The Psychotherapists Board of Aotearoa New Zealand has not consulted adequately with Māori practitioners**

Before the establishment of the Board, there were initial discussions between the New Zealand Association of Psychotherapists (NZAP) and the MoH about a “stand alone” authority or a “blended” authority (blended possibly with the Psychologists’ Board), there was a hope, even an expectation, that such a smaller, stand-alone authority would adopt the NZAP’s support for and work on biculturalism. Writing on behalf of the NZAP Council, Bailey, Quinn & Manning (2006) put it thus:

Access under the Treaty of Waitangi is best served by a stand-alone authority, in that the smaller the unit, the more flexible it can be in terms of biculturalism ... Our admission procedures, which we might hope will shape the criteria adopted by the authority, are flexible enough to accommodate indigenous method, belief and protocol. (p. 20)

Since its establishment in 2007 the Board PBANZ has demonstrated:

1. Its reluctance to consult adequately with indigenous Māori practitioners in the lead-up to registration.
2. Its reneging on an agreement to develop a Māori pathway to registration (see Dillon, 2011; Morice & Woodard, 2011). It has not adopted NZAP’s admissions criteria or procedures; and it was not present at a recent hui in which NZAP admitted four Māori psychotherapists/practitioners to membership through a Māori pathway.

---

1 This was a claim made by Māori that the downgrading of facilities and services at Napier Hospital by Healthcare Hawke’s Bay constituted a breach of Te Tiriti o Waitangi | The Treaty of Waitangi, for further details of which see Waitangi Tribunal (2001).
3. Its neglect for three years to agree on a policy about Te Tiriti o Waitangi | The Treaty of Waitangi (despite its claims to have one), and to have published it on its website. In September 2010, just a few days before the annual closing date for the renewal of practitioners’ Annual Practicing Certificate, the Board put a statement on its website regarding the Treaty (which it is due to review in August 2012) (see PBANZ, 2010). In fact, having finally approved a Treaty policy with weaknesses such as referencing the English version of the Treaty, the Board has failed to follow its policy: The Board has shown little interest in partnership with Waka Oranga or any other roopu of Māori psychotherapists nor in encouraging their participation in Board processes. Certainly only token attempts have been made to protect the particular interests of maori clients

4. Its refusal to acknowledge or engage with Waka Oranga, the national roopu of Māori psychotherapists and NZAP’s Treaty partner – all of which is especially ironic given the Board’s (2012a) claim to be familiar with and operating according to the Treaty.

5. Its insistence in adopting the English version of the Treaty inspite of the strong arguments that it is more appropriate to adopt the Māori version of Te Tiriti. The Psychotherapists Board in their policy states: “However, the Board specifically refers to the Treaty of Waitangi, as the version that is acknowledged in NZ law.” Which is simply inaccurate given for instance the statements in the Waitangi Tribunal empowering legislation. Furthermore there is every reason to value the Maori version of the Treaty since that is the one on the basis of which Maori signed the Treaty (as the Board acknowledges) and the international principle of contra proferentem holds that where there is ambiguity in a treaty it should be interpreted against the writer of the treaty. All of this is especially ironic given the Board’s (2012) claim to be familiar with and operating according to the Treaty.

In this context, it is highly questionable whether this stand-alone authority can operate with any integrity with regard to bicultural issues. It is, however, the Act that gives responsible authorities license to ignore Te Tiriti | The Treaty.

3. The review of the HPCA Act is inadequate with regard to bicultural issues

The original review of the Act focused on the operation of the Act rather than “its underlying policy settings” (Director-General of Health, 2009, p. iii), settings which were to be the subject of the next, i.e. this current review of the Act. For example, several submissions to the original review queried whether the Act should be amended to include a reference to the Treaty of Waitangi. The Director-General’s response was that this would involve consideration of the underlying policy settings of the Act and, therefore, be a part of the review in 2012. However, in the current Discussion Document (MoH, 2012), there is not a single mention of te Tiriti | the Treaty, none of the word “bicultural” and only one mention of “Māori.”
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: | Gary Strong |
| Address: (street/box number) | 4 Doon Grove, Papakowhai |
| (town/city) | Porirua 5024 |
| Email: | gary.strong@whitireia.ac.nz |
| Organisation (if applicable): | Paramedics Australasia New Zealand |
| Position (if applicable): | Committee member |

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 ensuring that the key focus is on the needs of and risks to the patient – not the needs of the profession. The current multiplicity of RAs mitigates against integration and encourages professionals to protect the boundaries of their profession rather than seek patient centred integrated care.

By ensuring that all professions with significant clinical responsibilities are regulated and encouraged to integrate. Paramedics make clinical decisions on behalf of around 1000 patients daily in New Zealand, yet remain unregulated thus far. This presents a barrier to integration with primary care services.

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

Comment:

Reduce the number of RAs and provide a common regulatory body such as the UK Health Professions Council. Provide a common set of procedures and expectations for (1) professional conduct and (2) clinical care and referral, ensuring that these are patient centric. Specific scopes of practice should be supplementary and complementary to this core body of standards.

The inclusion of paramedics under HPCA would bring a highly skilled and adaptable workforce into the health professional arena, offering significant opportunities for flexible working.

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?
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:

Provide a common set of procedures and expectations for (1) professional conduct and (2) clinical care and referral, ensuring that these are patient centric. Specific scopes of practice should be supplementary and complementary to this core body of standards.

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?

No

Comment:

Experience suggests the public are unclear about which professionals can provide which aspects of care, and this may always be the case. The consumer of healthcare is not too concerned with this, provided that he/she can access the right care rapidly. For example, nurse or paramedic management of wounds and minor fractures has been shown to increase patient satisfaction due to shortened waiting times.

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

Yes
Consumer focus

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

Comment:
The Act’s effectiveness could be improved in all these areas by reducing the number of RAs and having a single point of access for transparent information about health practitioners and consumer involvement.

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:
The dissipation of information across numerous web portals is confusing. A single point of access is required.

9. Do we have the right balance of laypeople to health professionals on RA boards?
   - Yes
   - No
Lay and consumer involvement is critical to ensure decisions are patient centric not practitioner centric. ‘Expert patients’ are required if available.

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 would be helpful provided there is one forum for a multiplicity of professions and not separate forums. Separate forums would not help with better integration.

   Representation should also be given to professions which are not yet regulated but provide high level services, e.g. paramedics.

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:

   The paramedic workforce engages daily in high stakes clinical decisions but is not covered by the legislation.

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 based systems generally lack external transparency. The interests of the employer may represent a challenge to impartiality when evaluating the actions of professionals. Employer led regulation undermines individual accountability.

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:

It appears there is significant overlap between the work of the numerous RAs, along with some confusion over the role of the RAs with regard to the role of the Health and Disability Commissioner. This may be an overlap of function rather than legislation, but there is a lack of clarity which leads to confusion for the healthcare consumer. Transparency is also an issue: legislation should ensure that RA and HDC decisions are open to public scrutiny.

As indicated above, there is a major gap in the current reach of the legislation with regard to the paramedic workforce, which engages daily in high stakes and largely autonomous clinical decisions but is barely mentioned in law.

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:

A generic health practitioner risk profile would help by providing an estimation of risk, assessed in categories such as

- Level of autonomy in the profession
- Risks attached to therapies available to the practitioner
- Level of access to confidential information
- Time spent unsupervised and engaged in clinical decisions

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

Comment:
A generic risk profile may help.

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:

Yes – but base line should be a generic profile for all those engaged in clinical assessment and decision making.

Cost effectiveness focus

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

Comment:

It appears there is insufficient attention to cost impacts, resulting in fee inequity across the professions.
Amalgamation of RAs may reduce overall costs and provide a better forum for employer liaison.

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

√ Yes

☐ No

☐ Not sure

Comment:
This is difficult but guidance is required. Public protection is the major reason for regulating a profession, and a framework is required for assessing

- the risk of harm posed by the clinical practice of the profession in general
- the risk of harm posed by the action of errant individuals within that profession

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:

A generic health practitioner risk profile would help by providing an estimation of risk, assessed in categories such as

- Level of autonomy in the profession
- Risks attached to therapies available to the practitioner
- Level of access to confidential information
- Time spent unsupervised and engaged in clinical decisions

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 range of regulatory options is helpful but ultimately confusing for the consumer. Also some professions which carry a risk of harm (e.g. paramedics) are not yet regulated.

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

☑ Yes
☐ No
☐ Not sure

Comment:
Reduce the number of RAs and provide a common regulatory body such as the UK Health Professions Council. Provide a common set of procedures and expectations for (1) professional conduct and (2) clinical care and referral, ensuring that these are patient centric. Share regulatory functions based on these core standards, thereby realising benefit from interprofessional judgments and experience. Share administrative functions to save costs. Introduce fee equity.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   √ Yes
   ☐ No
   ☐ Not sure

Comment:

Introduce an employer liaison function across the board.

23. Should the number of regulatory boards be reduced, as in the UK?
   √ Yes
   ☐ No
   ☐ Not sure

Comment:

As discussed previously. There are professional as well as cost benefits in sharing expertise and resources.

24. What is the ideal size of RA boards?

Comment:

If boards are amalgamated then the current minimum size of five may be insufficient, but the current maximum of fourteen ought to remain adequate.
25. Are there other issues you would like to raise?

Comment:

1. Many of the comments I have made concern the discrepancies and risks inherent in the fact that the paramedic profession is not yet regulated. With an application for regulation before the minister, and with significant experience from the overseas (UK, South Africa, Canada) within our workforce, I believe we are well placed to comment constructively on the future direction of HPCA.

2. As a profession we also have much to offer to the flexible workforce agenda, and regulation will help to facilitate this.

3. Does the Annual Practising Certificate have to be Annual? A two yearly recertification is unlikely to increase risk of harm, but would present a significant cost saving to RAs. It could also be interpreted as a vote of confidence in the professional responsibility and accountability of registrants.
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://hpcaatreview.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: Withheld

(name) ...........................................................................................................

Address: (street/box number) ...........................................................................

(town/city) .................................................................................................

Email: ........................................................................................................

Organisation (if applicable): ...........................................................................

Position (if applicable): ...................................................................................

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
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:

Health professionals already work collaboratively and did so before the enactment of the HPCA Act, however the definition of scopes of practice which is required by the Act, could be improved. The initial definition of scopes by RAs was very much along traditional lines and these could be modified to encourage more integration and less patch protection especially by medical professionals.

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

Comment:

Changes as in 1 above would assist, however it is important to focus on the principal purpose of the Act – public safety. Competence and safe practice of practitioners must remain paramount rather than using the Act to modify the 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? Not a yes no question!
The Act requires RAs to accredit educational programmes leading to registration so auditing of curriculum content and assessment is part of approval process. All the above content has been included in nursing programmes for many years – prior to the current Act.

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:

Am not convinced that standardisation is always of benefit – can inhibit innovation and critical analysis. While there has been some criticism of patch protection within some health professions too much blurring of boundaries results in lowered standards leads to confusion and lowered standards. Internationally introduction of new cadres of health workers has been of concern and any such change in this country must be carefully monitored. Motivation is usually cost cutting but effectiveness is questionable

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? Wording?

☐ Yes
☐ No
☒ Not sure

Comment:

I think most consumers would understand the broad scopes of practice but sometimes they (and individual practitioners) fail to grasp subtle differences in relation to specific tasks. The Act could be more prescriptive in relation to scopes of practice so there would be more consistency between RAs
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 should remain the responsibility of professional organisations/unions. RAs must be primarily concerned with competence and public safety. The way RA’s undertake these responsibilities (e.g. competence assessment, investigation of health and disability notifications) must be supportive of the practitioner but the public safety role must not be compromised by a pastoral care responsibility.

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:

Public safety is enhanced by the requirement of RAs to assess competency annually before issuing a practising certificate. The Act encourages/requires continuing education of all practitioners which also contributes to public safety. Appointment of lay people to RAs involves consumers in decision making however as members of RAs are appointed as individuals not as representatives of groups this is questionable. The role of the Act in keeping the public informed is also questionable – surely more a Ministry responsibility than that appropriate for RAs.

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:
Information from RAs is readily available on their websites but how accessible this is to members of the public is questionable. Am unsure of consumers’ use and knowledge of complaints processes – would think this was more readily accessed via Health and Disability Commission and Advocacy Service and that is appropriate as there is excellent communication between the HDC and RAs.

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

☐ Yes
☐ No
☐ Not sure

Comment:

Balance with regard to numbers yes but contribution dependent on the individual. As laypeople are all appointed by the Minister there is potential for political bias and representation of only a narrow 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:

I believe this is a fairly recent development in the UK and am not aware of reports of usefulness or otherwise. Such forums may be useful though there is a possibility that they are merely repetitive airing of grievances which achieves something only for those doing the airing usually.

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:
As answered above I consider the Act has contributed to public safety but I’m not sure whether this is the “best use” of legislation. The Act has been in force only 8 years and has been reviewed twice to my knowledge. It seems to be working well but some amendments as have already been identified could improve it. One area for much consultation is the appropriateness of regulation for each group of health practitioners. Is regulation required for e.g. dietitians, anaesthetic technicians (who must be supervised by anaesthetists) or other groups where the risk to public safety can be minimised by other means.

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:

See answer to Q11 – for some groups of health workers other means of oversight could be appropriate, however statutory regulation provides consistency and works well in a small country. Experience with the Employment Contracts Act which introduced wide variations in conditions across the country demonstrated the advantages of a nation-wide approach for New Zealand. Bulk purchasing of e.g. equipment and pharmaceuticals as currently supported by the Minister is an example of the current moves away from “de deregulation”

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:

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

Comment:

By adhering to their profession’s code of conduct and being thoroughly conversant with the requirements of the various Acts which govern their practice. By ensuring they maintain their competence with continuing education and peer review. By membership of professional association(s) and networking with others in sole practice.

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 is perhaps more the role of professional associations and employers.

Cost effectiveness focus

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

Comment:
I am familiar only with the Nursing Council and am aware that the cost implications of all decisions are carefully analysed before the decisions are made. I am not sure that all RAs are as concerned re costs as the Nursing Council.

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

☐ Yes
☐ No
☒ Not sure

Comment:
A definition could be included to clarify for practitioners in what circumstances their practice would be considered unsafe. I don’t know that a negative approach is best however – defining safe practice is more important.

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:
I’m puzzled that these questions re risk are included in the cost effectiveness focus section.

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

☐ Yes
☐ No
☒ Not sure

Comment:

I am aware that the Nursing Council has a quality programme and regularly assesses its performance and amends processes accordingly. I don't know if other RAs do the same but I am sure none would claim to be perfect. Any changes need to be for the better however not according to political whim.

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

☐ Yes
☒ No
☐ Not sure

Comment:

Current consultation requirements appear sufficient.

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

☐ Yes
☐ No
☒ Not sure

Comment:
As discussed in an earlier question there may be some existing boards whose function could be just as effectively carried out by other legislative means so that would reduce the number of RAs, however there are unregulated health workers for whom regulation is being sought/recommended. Reports from the changes in UK and Australia are not universally positive and any change to existing RAs in this country needs to be implemented with great care and for the right reasons. Cost cutting is not sufficient justification.

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

Probably 8 to 10 is an appropriate size depending on the number of practitioners they regulate and how they organise their processes. While not involved in day to day operations members of RAs must have full knowledge of these and oversee and assess their effectiveness and efficiency. They must also be responsible for appropriate delegation but I believe decisions regarding suspension or discipline must be made by RA members not just rubber stamping of staff recommendations.

25. Are there other issues you would like to raise?
Comment: As a nurse I have major concerns about the proposal to merge RAs in order to reduce costs. As the profession with the largest number of practitioners to regulate the Nursing Council benefits from economy of scale but it has also developed very efficient and effective processes. It is fully funded by nurses’ practising certificate fees and by cost recovery for services such as audits. As nurses are amongst the lowest paid of the health professions it would be grossly unfair for them to be forced to subsidise other professions which would be inevitable should the merger proposal proceed.

A glaring omission from the review of the HPCA Act is the impact of its establishment of the Health Practitioners Disciplinary Tribunal. While many welcomed the supposed “independence” of the tribunal and regard its operation as effective its efficiency has not been appropriately analysed. RAs are required to meet all costs of the Tribunal yet have no control over these costs. Nursing practising certificate fees have been increased because of the increase in costs for disciplinary proceedings. There should be involvement and some control by the RAs in budget setting for the Tribunal.
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: Paul Davey

Address: (street/box number) 90 Akoranga Drive
(town/city) Auckland

Email: paul.davey@aut.ac.nz

Organisation (if applicable): Auckland University of Technology

Position (if applicable): HOD Paramedicine and Emergency Management

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
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:

Regulation is essential to protect public safety, registration is often inappropriately seen as vector to elevate health workers to health professionals with a hierarchical dichotomy of those that are registered and those that are not. The current system of registration supports silo’s of independent clinical practice. Health professions should be rightfully proud of their identity but should not use registration as a means of attaining a quasi-professional status. One way HPCA Act could strengthen integration and interdisciplinary approach is to change the function of the RA’s to reduce their complaint management function – appropriate practitioner representation could occur at the HDC and HPDT level as required.

I disagree with introducing new named health professions into the New Zealand health scene – such as the physician assistant, but I do agree with the concept. The HPCA Act needs to overtly permit a registered practitioner with appropriate training and education to extend their scope of practice to meet the health work force needs. An example would be using an appropriately trained paramedic or nurse in a rural medical centre working both in the medical centre with an extended scope and providing emergency care outside of the medical facility as required.

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 facilitating appropriate registration based on a risk of harm stratification model that is patient centric and not prescribed or dictated by NGO’s, employers or the practitioners/health providers willingness to register. The safety concern should be the public’s not the practitioners. This needs to be balanced to ensure that the maintenance of registration is achievable and embedded in practice – the solution must be pragmatic and transparent.

The RAs need consolidation which may facilitate a reduction in the apparent scope protection mentality – any scope that has a focus of independent as opposed to interdependent practice should be reviewed. There needs to be mechanisms for scope expansion - for example an appropriately educated paramedic at postgraduate level should be able to perform primary care functions, for example immunisation, smoking cessation, prehospital thrombolysis and respiratory rehabilitation. This is especially the case in rural New Zealand. Likewise the primary health management of many urban presentations may be managed in the primary care setting by ambulance (such as fall assessment and suicide screening) with appropriate referral mechanisms in place.

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:

Yes: working in teams reflects clinical reality – training and education should incorporate team training and communication skills and this should be considered core not a wider focus. The RAs currently have the function of accrediting educational programmes (as does the Ministry of Education / Tertiary Education Council). The HDC Office has an educational focus, perhaps this would be a more appropriate accreditation avenue. Most undergraduate programmes have intradisciplinary team training but very few have interdisciplinary team training. Simulation is a powerful tool for interdisciplinary team training however simulation is capital and operationally rich – who funds this? The lack of high fidelity simulation capacity is a limit – Health Work Force Australia seeded simulation funding into tertiary health schools to the tune of many millions of dollars.

No: Consumers self-management should be a function of the Ministry of Health and not embedded in the HPCA Act

4. Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?
Ethical dimensions of practice could be generically aligned as could codes of conduct for many like health professions with addendums of professional specifics. As this currently is a responsibility of the RAs the HPCA Act has a clear role in alignment and standardisation of such. Common learning across health professions is an essential aspect of interdisciplinary education. Tertiary providers should demonstrate this commitment at accreditation audits. This is a strong feature of the health education at AUT with approximately 1/3 of all undergraduate health papers being shared across disciplines. For example whether you are enrolled in Paramedicine, Nursing, Midwifery, Oral Health, Physiotherapy or Podiatry etc you engage in common papers – this fosters interdisciplinary learning giving opportunity see health issues from various perspectives.

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:

The scopes are written broadly at a higher macro competency level, as they should be. However these scopes do not inform the public adequately as to what level of service or performance/interventions that you can expect from an individual practitioner. More information is needed – the problem with a micro approach is that you end up with a very prescriptive skill based competency framework that may still not adequate inform

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:
This should be the role of the employer – health is regarded as an environment prone to horizontal violence and bullying – the employer has a responsibly to manage this culture. The Health and Occupational Safety legislation is a better avenue for this. Self employed health practitioners that work in isolation may be penalised by this approach. Pastoral care is important but the focus of the HPCA is to protect the public, whilst you could argue that pastoral care of the health practitioner may secondarily protect the safety of the public, it primarily serves the health practitioner.

**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 HPCA Act goes a long way to achieving its public safety focus. With respect to complaint management there is a complete lack of transparency at the RA level which is an impediment to keeping the public informed – this is in contrast to the complaint management at the HPDT level. There appears to be a strong consumer focus at RA level in that it have members of the public on the RA board – are these ‘public appointees’ representative of the public served by the RA?

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:

This process is not sufficiently transparent which limits the ability of the public to make use of such information – I would argue that the RAs should refocus its energy from complaint investigation and invest more in standard setting, scope development, register maintenance and competence confirmation. The complaints investigation should be left to the independent agencies such as the Health and Disability Commissioner and the Health Practitioners Disciplinary Tribunal.

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

☐ Yes
2012 Review of the Health Practitioners Competence Assurance Act 2003

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:
   
   You would be better to engage in more public consultation and reduce the balance of laypeople on the RA boards – for example a health law or ethics representative may be more useful – the RA should be representative of the health professions that it represents.

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:
   
   Whilst this will have a cost implication I believe that they may be insightful.

**Safety focus**

The double edged sword of the Accident Compensation Act – yes it does protect the practitioner and significantly limits litigation for error – no fault finding – although this does potentially reduce the cost of health care provision and makes new Zealand an attractive place to practice I am not sure that we have achieved the degree of openness lauded – why is the medical error rate still high in New Zealand. The management of complaints and breaches of the Code by unregistered health and disability services providers is less than desirable. The HDC Act provides for reasonable prompt low level resolution of health and disability consumers complaints but the Commissioner may benefit greater powers of redress.
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:

Historical performance would not support the regulation pendulum swinging from a statutory regulation system to more of an employer based risk mitigation regulation system. One could argue that statutory regulation systems are necessitated as a consequence of failures of self regulation. These failures created divergence from patient centricity and posed public safety threats in New Zealand. In my opinion there are undisclosed power discourses and financial pressures both internally within the health professions and employment arenas that potentially albeit not purposefully may diminish the effectiveness of self or employer based regulation models. The foundations of the HPCA Act; to protect the public and to create an equitable single route for management of health complaints/practitioner performance is sound.

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:

There needs to be a better mechanism for managing health workers/providers that pose low threat profiles and consolidation of the regulation infrastructure (RA’s) to mitigate cost. In addition the HDC Office (and Act) needs to have a greater role in accreditation of educational programmes (undergraduate and postgraduate) The Commissioner should have greater power (legislative teeth) to resolve breaches of the Code at the lower end of the spectrum that are enforceable with a trilogy of education, apology and cost recovery penalty, the process needs more teeth. Appeal could be through the HPDT which would also adjudicate over the more significant breaches of the Code and of the HPCA Act.

There needs to be a better mechanism to amend the Medicines Act 1981 and Misuse of Drugs Act 1975 to better reflect clinical practice reality and better define educational and practice around prescribing.

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:

Whilst the level of risk desirable for statutory regulation needs to be balanced by the achievability of regulation, cost and impact of risk realisation the primary focus of protecting the public still remains. The likelihood of serious harm (frequency and acuity constraints), level of autonomous isolated practice and absence direct supervision should help guide the tendency towards statutory regulation. Health and disability service providers with low risk profiles could have a self regulation model through a professional body that is independent of employers.

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

Comment:

There should be peer review and audit processes available and communities of practice established for those that work in sole practice.

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:

High risk professions should have the same RA – there may be reluctance on the basis of other professions not understanding the complexity of an individual profession in relation to the risks, practice and specialist knowledge – but the composition of the RA and compensate for such and advice can be sought when comparing competent to sub-optimal performance. Issues of character are universal.

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 cost impact can be mitigated by reducing the number of RAs and consolidating functions—In many professions the RA charges the member fees which is then reimbursed by the employer—for example DHBs—this cost has a direct impact on health delivery capacity of DHB’s which is funded via taxation—the public are effectively paying for their own protection.

18. Should the HPCA Act define harm or serious harm?
   ☒ Yes
   ☐ No
   ☐ Not sure
   Comment:
   Guidance should be given to ensure that RAs are not required to formulate their own interpretation—difference interpretations may lead to different levels of public protection

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:
   Same as question 14

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
2012 Review of the Health Practitioners Competence Assurance Act 2003

Comment:

The lack of transparency of the RAs compliant investigation process and outcomes needs addressing.

Paramedics in New Zealand are not currently registered – this is an incongruity as paramedic practice has high autonomy, is not supervised directly, requires clinical decision making in isolation and involves procedures and drug administration (ketamine, midazolam, morphine, fentanyl, nitrates etc) that have the potential to cause significant harm.

21. Could the way RAs administer their functions be improved?
☐ Yes
☐ No
☒ Not sure

Comment:

I am not convinced that the RA is the correct group to manage complaints – this should be independent with representation from the profession – the process should also be transparent and conducted by HDC or HPDT. The Focus of the RA might be better suited to scope setting, code of ethics and conduct creation, competency audit and maintenance of the register.

22. Should RAs be required to consult more broadly with relevant stakeholders?
☒ Yes
☐ No
☐ Not sure

Comment:

There needs to be a closer working relationships and consultation between the public, employers, RAs, educational providers and the Government (MOE and MOH), HDC Office

23. Should the number of regulatory boards be reduced, as in the UK?
☒ Yes
☐ No
☐ Not sure

Comment:
There is an absolute need to radically change the structure of the RAs to remove the redundancy and duplication that has unnecessary cost implications. Having ‘your own’ RA should not be seen as the essential entity that defines your professions worth. There could be three to five RAs that would be supported by one central secretariat. The delineation of professions could be based on risk of harm into high, medium and low risk. The high risk group could include medical doctors, nurses, midwives and paramedics for example. A risk stratification model would facilitate integration and inter-professional cross pollination from multiple disciplines.

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

8-10 people

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

NZ is unique in its approach to health law and health practice that creates an environment less focused on litigation and more focused on social support. Moving into the future we need look at novel models to make best use of the health work force and available funds. The backbone to this I believe is in strengthening and expanding scopes of practice within the primary healthcare context.

The competency cycle and practicing certificate should be extended to two or three years cycles as opposed to an annual event. Revenue could still be collected annually.

I believe that appropriately trained Paramedics are a currently an unrecognised solution to the health work force need in primary care both in urban and rural clinical practice domains.
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 pcaactre view.hiirc.org.nz.

The closing date for submissions is Friday 26 October 2012.
Submitters’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: Andrew Charnock

Address: PO Box 10-202
Wellington

Email: andrew.charnock@osteopathiccouncil.org.nz

Organisation (if applicable): Osteopathic Council of New Zealand

Position (if applicable): Registrar

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): RA

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:

- The accreditation and monitoring of programmes could direct RA’s to identify how educational institutions demonstrate how the curriculum provides for interprofessional learning. This is easily facilitated as most health care professional’s education and training takes place in the same institutional setting and would allow for cross fertilisation in undergraduate and postgraduate education. The osteopathic profession may be seen as isolated as all practitioners are in private practice. This presents challenges in providing integrated care. As a profession osteopathy tends to be under utilized, yet research undertaken by Council on ACC data demonstrates the efficacy of osteopathic intervention when compared with other manual therapies. How the profession becomes more integrated into main stream healthcare provision is perhaps beyond the scope of the review.

- Scopes of practice for professions need to be broadly defined allowing for growth both across the specific practice of the profession and enabling them to flex when models of healthcare services change. When practitioners are working at a higher level within their scope they should be given principled guidance from RAs to allow them to work at that level. The Council is developing further its vocational and extended scopes of practice in gerontology and pain management. One of the prime reasons for this development is to have a skill set to align with emerging healthcare needs within an interdisciplinary approach to care. Council see this as future proofing the profession.

- RAs need to be cognisant of the Government’s health agenda and targets. There has to be a growing connection between the targets and how the scopes of practice of the health professions allow particular professions to meet those targets. This requires the scopes to be flexible or allow for vocational scopes of practice to be developed by RAs. A change to the legislation which allows RAs to adapt quickly to health needs by introducing vocational scopes would be one way to match changes to services model delivery with a particular profession’s practice.
2. How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?

Comment:

- A simplified and expedited process for registering overseas trained practitioners may be of benefit to practitioners, employers and consumers. But this has to be balanced with appropriate assessment of competence to practice in the New Zealand context.

- The premise of the HPCAA was the protection of the public and not the promotion and delivery of a flexible workforce. There would need to be a change in the legislation which would recognise the need to connect the RA with workforce issues. This could be managed by extending the functions of the RA under section 118.

- The development of MoU’s between RAs in other jurisdictions allowing practitioners to move freely between different countries. It would be helpful for the legislation to facilitate this formally. It is important that the HPCAA is viewed internationally as well as nationally, as New Zealand relies heavily on attracting overseas trained practitioners.

- There is a need for RAs to develop clear connection with the immigration service. Often overseas practitioners have to deal with 2 complex bureaucratic systems – RA and immigration. The development of a streamlined “one stop shop” allowing practitioners to register and obtain visa clearance should be investigated.

- A section within the Act that allows RAs to permit practitioners to enter a research and innovation scope of practice. If this section is connected to health agenda targets and is underpinned by demonstrable knowledge/skills/experience of the practitioner then it could fast track health outcomes and allows the workforce greater and quicker flexibility. If this facility is connected to local ethics committees it would help mitigate risk and provide a monitoring process.

- Strengthen section 118(a) and expand the monitoring functions so that it specifically looks at undergraduate and postgraduate programmes and their connection to innovation in healthcare and interprofessional practice.
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:

- The Act could promote common strands of learning including: communication, teamwork and cultural safety (last point has not yet been mentioned). Cultural competency could be supported through online courses such as Mauri Ora: http://www.mauriora.co.nz/web/index.php/courses/courses-list/62-foundation-course-in-cultural-competency

- The development of key generic standards for all health professionals would go some way to ensure that essential skills such as communication and team-working are promoted. Standards in written communication and interprofessional etiquette could also be developed.

- A shared standardised code of ethics and code of conduct across all the health professions.
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:

- Yes, the Act could specify a generic code of conduct for regulated Health Care Professions. There appears to be significant overlap between codes of conduct for different health care professions and it is believed that a joint code of conduct would be beneficial for practitioners, employers and for consumers of health care services.

- It would be important for the codes to be written as principled minimum standard documents. This would allow professions to supplement codes reflecting their particular practice setting and client group.

- With respect to common learning – the United Nations is calling for all health care professions to recognise and take action to address the social determinants of health: http://www.who.int/social_determinants/en/. It is recommended that interdisciplinary learning in this area is adopted within the HPCA.

- Strengthen requirements for reflective practice and make the connection explicit to patient outcomes with a standardised continuing professional development (CPD) model. Having a standardised CPD model tied to outcome would also augment team working. The connection to Government health targets would also be beneficial.
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:

- The Council is presently consulting on scopes of practice. It has taken care to ensure that the wording in scopes describe the practice and skill required for the particular scope.

- There is still potential to have a better informed public about what to expect from health practitioners. Most people understand and use the HDC code of patients’ rights, maybe it is time to develop a similar code so people understand what to expect from health practitioners.

- Plain English versions of the scopes of practice. Most scopes are written for the particular health profession. There is potential to change the language so that it reflects better what people can expect from a health practitioner. In short the scope is written for the person seeking the health service not the professional group providing it.
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:

- It is difficult to see under current legislation and processes how RAs could both potentially “punish” as well as support practitioners. Such activity may be a better fit for the associations.
- There is potential to look at a supportive agency which sits outside the RAs. For example, following the example of the National Clinical Assessment Agency in the UK may be a better option for supporting practitioners before they fail as well as pastoral support when they do.
- Our experience is that we do support practitioners and we see this as a clear role for the Registrar. Allowing operational staff to provide pastoral care allows the Board to remain at arm’s length, and in so doing maintain objectivity.

Consumer focus

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:

- Training for governance on RA boards should be centralised and the development of key governance competences should be developed.
- Some smaller RAs rely on practitioners on the RA to progress work and projects because they do not have the same operational resources as the larger RAs. Shifting the ratio of practitioner to layperson may have some impact in this area.
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:

• Greater connection between HDC, ACC and RAs activity and reporting so that trends can be produced and inform practice and regulation.
• A generic document to be published for the general public which is written in plain English and explains the role and functions of RAs.

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

☐ Yes
☒ No
☐ Not sure

Comment:

• See point 7 above.

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:

• HDC advocacy service and connections to RAs working more closely together to respond to lower level concerns (complaints) to arbitrate and reach consensus.
• Consumer forums that relate to healthcare modalities rather than diseases would provider a richer resource.
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:

- Improve CPD activity so it more closely relates to health targets rather than individual professional aspirations.
- Strengthen recertification programmes as described in section 41. Having a formally identified recertification programme allows RAs to have clear and decisive action with failing practitioners by using section 43.

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:

All osteopaths are self employed.
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 development of a national clinical assessment agency, which has a no faults no blame function in supporting practitioners and employers.
- Further development of the credentialing process but to tie such activity in with the RA. Having such a connection may reduce the need to develop time consuming scopes of practice.

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:

- Having risk clearly defined in the Act would help.
- Having flexibility to make a judgement of whether to refer a matter to a PCC reference section 67.
- The discourse in risk needs to include acts of omission and failures to direct patients for appropriate investigation / treatment. Narrowly focussing on risks associated with procedures is self evidently inadequate.
15. Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?

Comment:

- Recertification programme has a mandated section and requirement for those in sole practice to have face to face peer meetings or peer review activities.
- A credentialing process which is specific to sole practitioners.
- Auditing process requiring a practice visit.
- Development of practice guidelines (generic) for practitioners in sole practice.
- The Act as it is currently framed is effectively relying on complex governance structures in the employment sphere to ensure that the spatial aspects of practice are regulated. In the osteopathic profession there are no complex external governance structures in the employment sphere and it is an obvious failing that the RAs are left with no powers to ensure the practice environments are safe. Creating appropriate standards and resources for small organisations / sole practitioners would be a welcome development.

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:

- RAs ought to be able to direct attention and resources where they have particular evidence that a certain category of practitioner is a real risk to patients. For example we know that male, pale and stale practitioners are the real risk to patients. Not sure if it’s practitioners at high risk or the type of practice undertaken by the practitioner. It may be that we need to look at activities performed by practitioners rather than a blanket approach to all practitioners. However, clearly defined scopes of practice help clarify and mitigate risk in this area.
- Intelligence from competence, health and conduct could be better analysed allowing trends and themes on risk to be better profiled.
Cost effectiveness focus

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

Comment:

- Having shared in-house legal advice could allow for a more efficient and cost effective service.
- Development of a database on legal decisions and interpretation of sections of the Act would be a useful resource for all RAs.
- It would be our contention that RAs are conscious of the cost of decisions and the effect this has on regulation. This of course is a balance between management of risk and public protection with the latter being the primary influencing factor in any decision.

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

☑ Yes  
☐ No  
☐ Not sure

Comment:

- Yes, it appears that this would be useful to define within the Act.
- Defining harm would be better expressed in the form of principles which would allow RAs to apply a lighter or heavier touch to their particular professional group dependent on risk of harm to the public.
- Public perception is a factor that is considered yet poorly articulated within the Act. Strengthening reference to public perception within the Act would be helpful.
- Serious harm needs to explicitly deal with acts of omission and the focus broaden from the procedural issues to health outcomes.

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:
• It is our view that the document produced by the Ministry earlier in the year has already provided criteria for assessing risk.
• Development of a matrix of “external controllers” for health care provision may help map other forms of regulation which fall outside the Act yet allow for some form of regulation. This is very dependent on the standing of the other agency which could potentially provide an external control, for example credentialing or membership of an association.
• See 18 above

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:
• Our present experience is that the regulatory functions at present allow us to manage risk. Our only comment would be the speed at which a practitioner can be stopped from practising while allowing for natural justice.

21. Could the way RAs administer their functions be improved?
☐ Yes
☐ No
☒ Not sure

Comment:
• Consideration should be given to the development of a single, secure, nationally accessible database. In addition to workforce planning, consumers would be more likely to check that a health professional is appropriately registered, if the information on all health professionals was easily available.
• There are a number of common activities that RAs perform that would lend themselves to improved and streamlined administration through a single organisation. The important element in any improvement would be the establishment of a single IT platform that allows for consistent processes for some RAs while allowing for bespoke activity for others reflective of risk factors to practice.
22. Should RAs be required to consult more broadly with relevant stakeholders?

☐ Yes
☐ No
☒ Not sure

Comment:

- It could be argued that RAs need to consult more broadly with relevant stakeholders, in particular consumers. The problem with this approach is the identification of consumers who could provide an objective and balanced approach to consultation.

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

☐ Yes
☒ No
☐ Not sure

Comment:

- Not the number of RAs but the administrative functions of each RA could be streamlined as outlined in 21 above.

24. What is the ideal size of RA boards?

Comment:

- Not simply for the sake of it, only if evidence supports this move. This is also dependent on the decisions that the RAs are making – are they making decisions that are discipline specific?
25. Are there other issues you would like to raise?

Comment:

The TTMRA legislation (section 16 (a)) precludes RAs from applying any new conditions on the scope of practice of practitioners. This presents an anomaly between the Australian and New Zealand jurisdictions when for safety and management of risk the New Zealand jurisdiction would want to put conditions on the scope of practice. This can be further compounded by overseas practitioners registering in Australia (with no supervision on scope) and then under TTMRA applying for registration in New Zealand which would have a condition on scope of practice for this type of practitioner.
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: Phillip Cottingham

Address: PO Box 78-229

Email: Principal1@wellpark.co.nz

Organisation (if applicable): Wellpark College of Natural Therapies

Position (if applicable): Principal

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
X Academic/research ☐ Māori
☐ Pacific ☐ District health board
X 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?

X 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:
Integration between Complementary and Alternative Medicine (CAM) and Conventional Care (CC) is already occurring in New Zealand. However, this occurs in an informal manner primarily (Vempati, Dunn, Cottingham, Sibbritt, & Adams, 2012).

With the increasing use of CAM by the public (A Portrait of Health: Key Results of the 2006/07 New Zealand Health Survey, 2008, pp. 299-300) it is important that suitably qualified CAM professionals are recognised under HPCA to create an environment where there is better and more open communication (CAM with CC; CAM with patients; CC with patients), which enables integration to better serve the needs of the patients. We would argue that this lack of communication (often because of lack of regulation of CAM) leads to a potential compromising of patient safety.

The HPCA act needs to widen its safety focus to include the potential risks of lack of formal processes (referral mechanisms, sharing of patient information and forums for dialogue between CAM and CC), which could compromise patient safety.

Recognition of suitably qualified CAM professionals could also play a large part in shifting the focus of integrative care away from treatment to prevention, as the focus of CAM, whilst concerned with treatment, has a greater inclusiveness of health promotion and prevention of illness (particularly chronic illness).

Consolidation of the RAs will assist complementary medicine practitioners in both administration and costs, which will help. We are certain that other smaller groups of practitioners are also in the same position, and we support this proposed consolidation. Hence our preference would be for:

A single national administrative secretariat & fewer RAs (suggest 4 or at max 5) based on risk of unregistered/unqualified profession and/or treatment & commonality of practice:

1. (e.g. medical related [nursing, doctors, specialists, midwives, pharmacists]);
2. Medical related allied health professions (e.g. optometry, optical dispensing, medical laboratory science, radiation therapists, anaesthetist technicians, dialysis technicians, paramedics, podiatrists)
3. Dentistry [dentists, dental hygiene, clinical dental technology, dental technology, dental therapy]
4. Other allied health professions [occupational therapy, dietitians, nutritionists, counsellors, psychologists, psychotherapists, hypnoterapists, physiotherapy, chiropRACTICS, osteopaths, massage therapists, yoga therapists, naturopaths, medical herbalists, homeopathics, traditional Chinese Medicine, acupuncture, Rongoa Maori healers, Ayurveda practitioners].

Have only 2 community members (lay people) on each board [at least one Maori].

The RA should manage the following:

- Registration process (includes English standard skills; criminal history registration standard, currency of practice registration standard, continuing professional development standard, automatic expiratory of registration, new common renewal date)
- National data collection
- Mandatory reporting
- Publishes national registrar
- Professional conduct/misconduct
- Works with HDC to investigate community concerns, disciplinary hearings
- Registration standards, competencies, scopes of practice
- Registration renewal, standards, competencies, scopes of practice
2. How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?

Comment:

Recognition of CAM professionals could tap into a health workforce whose potential is underutilised in the spectrum of healthcare. As stated, integration (of CAM and CC) is unlikely to be fostered without such recognition. We contend that this recognition needs to be under the auspices of HPCA with suitably qualified CAM professionals.

A study published in 2012 stated “CAM users present with risk factors which are priority public health issues……. CAM encounters may provide opportunities to coordinate health promotion and prevention messages with patients’ primary care providers” (Hawk, Ndetan, & Evans Jr, 2012). This indicates a real role for CAM in addressing those sections of the NZ Health Strategy (King, 2000), a view endorsed by CAM professionals surveyed in the ‘Mapping the Natural Health Landscape’ study (Vempati, et al., 2012).

Complementary medicine practitioners can actively educate/treat the public in terms of identified NZ health strategies & should be used more widely in health promotion/maintenance & disease prevention. Recognition would then allow for greater flexibility, particularly in allowing CAM professionals to play a significant role in healthcare teams (clinical and community based), particularly as they are able to dedicate a considerably greater amount of time to patient’s healthcare needs than CC (Heiligers, de Groot, Koster, & van Dulmen, 2010; Vempati, et al., 2012). We argue that this would create a greater ability to respond appropriately, given the greater understanding created by spending more time with patients. We also argue that funding given to health promotion and disease prevention through utilisation of CAM professionals would be a better use of resources than the current allocation weighting to Primary and Secondary services.

The HPCA should be utilised to remove barriers associated with health professions and increase integration by grouping professions in terms of commonality of practice e.g. dietitians, nutritionists, naturopaths, psychologists, psychotherapists, counsellors, hypnotherapists. Limitations could be set around level of scope of practice e.g. dietitians provide specialised diets within the hospital setting, nutritionists and naturopaths provide nutrition in a clinical or community setting, including community education.

The HPCA could provide a structure that enables the utilisation of allied health professions in integrative medicine practices, which would create a system for best management of patient that encourages self-responsibility in health & reduces budgetary pressure on health care while ensuring that best practice medical treatment is available when required.

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?

X Yes
☐ No
☐ Not sure

Comment:

The question cannot be answered through a yes/no response. If CAM education has a greater opportunity to utilise projects/clinics within the current health care provision for training purposes/internships, etc. CAM practitioners potentially have a significant role to play in health care teams and integrative provision, particularly in supporting consumers self-management of chronic conditions. For this to occur, recognition, through registration under HPCA is essential. Therefore HPCA needs to ensure that its criteria and processes can facilitate such recognition for CAM.

It could also:

- Require core health education papers relevant to all health professions e.g. anatomy & physiology (level 7 degree level)
- Deliver a core educational programme that educates all health professionals about the competencies, scopes of practice of other health professions under the Act
- Encourage a structure that enables Continuing Professional Development to include cross-professional education
- Encourage a structure that supports collaborative research projects between professions
- Encourage a structure that enables a hospital, integrative clinic, community based programmes component in all health professionals training so that all health professionals communicate and understand where different professional expertise lies

Require NZ education system to extend number of years of student access to funding to provide sufficient education to achieve these outcomes

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

X Yes
☐ No
☐ Not sure

Comment:
Possibly through a framework that contains common core of ethical standards and processes, with each profession having additional criteria and processes that meet the particular needs of that profession.

This can be achieved by:

- Requiring common education courses across all training institutions of health professionals.
- Have common CPD requirements around codes of conduct & ethics.
- RAs should have common statutory regulation, standards & monitoring of codes of conduct & ethics and where breaches occur should be communicated and used as a form of education to improve operation of all RAs.
- All CPD could require online CPD examples of breach of codes of conduct & ethics as an ongoing education requirement (as opposed to RAs keeping such breaches under wraps & negating the learning opportunity for all health professions).

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
X Not sure

Comment:

Somewhat difficult to answer without examples of Scopes of Practice but, in general, we would submit that Scopes of Practice require some flexibility but, where that flexibility impinges on the core scope of practice of another profession (massage, physiotherapy, chiropractic and osteopathy are modalities where this is possible), there needs to be a forum whereby guidelines will need to be developed.

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

X Yes
☐ No
☐ Not sure

Comment:
Through a CPD process such as:
1. Utilising supervision as a tool for learning about oneself as a health professional & improving the therapeutic relationship
2. Requiring supervision associated with overseeing the required skill set is met when there has been some breach in professional health care.

Currently DHBs provide supervision for health workers within the hospital system. This requires extension outside the hospital environment to ensure the health & safety of the health professional & to prevent burn-out & errors being made. All community based workers should be known to the local DHB and fit into their current system.

This should be put in place for all health professions (up-skilling & supervision) where there has been a breach in ethics, quality practice to ensure a minimum standard to met before being able to resume practice (temporary loss of registration until requirements are met).

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
X No
☐ Not sure

Comment:

Many health professions are not currently included under the HPCA Act e.g. paramedics, complementary medicine (main modalities: naturopathy, herbal medicine, homeopathy, massage therapy, traditional Chinese medicine, acupuncture, Rongoa Maori, Ayurvedic medicine).

Other CAM practices should require national self regulation and should not be able to prescribe an oral or invasive treatment without regulation under HPCA 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
X Not sure

Comment:
Many complaints made against complementary therapists are made in the public arena (newspapers, television) and occasionally reach the associations. (It must be said that these are small compared to national statistics of complaints made to Health and Disability Commissioner)

A more transparent process between RAs, other health professions & the public would be advantageous and would result in improved learning for all health professions and the public. We suggest that there is documentation on a combined RA health related website. This could be used by education institutes for training in ethics and code of practice. Could also be drawn on for coverage of such under CPD.

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

Comment:

There should be one member from each RA on each of the other RAs so that there is cross communication. This will ensure consistency and knowledge sharing across RAs as opposed to maintaining a protectionist or elitist stance of the particular profession.

There should also be three consumers/lay people on an RA board: a lay person, at least one Maori rep. & a disabled person on each board for consumer representation especially of marginalised groups [Maori, disabilities]. Could be same 3 people across all 4 RAs (again for consistency & transparency). Other minority cultures, such Pasifika and Asian would also need some form of representation.

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:

Would provide constant accountability and quality improvement. Stakeholder forums are utilised in other spheres, such as education, councils, etc.
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?
   X 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
   X Not sure
   Comment:

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:

   Inclusion of other health professionals currently excluded under the HPCA Act e.g. paramedics, main complementary medicine modalities: herbal medicine practitioners, naturopaths, homeopaths, massage therapists, traditional Chinese medicine practitioners, yoga therapists, Ayurveda practitioners, Rongoa Maori practitioners, hypnotherapists.

   Reducing RAs to 4 (as per question 1) based on commonalities of practice.
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 word “risk” is not defined in the act at all. This indicates that there is considerable uncertainty as to what constitutes “risk”. CAM professionals would argue that there is a risk unqualified practitioners practiced certain modalities. The list of modalities could be wider than is previously thought. A short list could include: herbal medicine; massage and body therapies; naturopathy; yoga therapy; hypnotherapy and Ayurvedic medicine. The risk is not only in having unqualified people practising, but also in the ability to communicate with other professions (referrals, sharing of records, etc.).

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

Comment:  
Peer review systems need to be instituted for all professions. These systems would allow the community of professionals to better manage risks and, in most cases, prevent serious harm occurring.

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:  
However, risk profiling is a contentious issue. Such profiling could only be created from within a profession. Risk is also commonly a result of work and life conditions and is not a constant, but a very labile situation. We need to be careful, but also to be able to assure the public of practitioner’s safety. This will need careful consideration.
**Cost effectiveness focus**

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

Comment:

Cost-benefit/risk is also a contentious issue. It can become a pragmatic requirement due to financial constraints. RAs have a responsibility to consider cost impacts & cost benefits of regulation. It is important that there is a good basic structure (from the top down) that is not overly burdensome or imbalanced and that provides the consumer with safety and good quality health care.

---

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

   X Yes
   □ No
   □ Not sure

Comment:

If the HPCA Act is the major vehicle to protect the public from harm, it needs to clearly define harm and build that into policy. If “harm” is undefined the Act has the potential to create inconsistencies (which it has) and pluralistic health system: one which is nationally recognised (title protected, national education standards, CPD, disciplinary policy & related procedures) and another more marginalised one (no title protection and no required education standards nor required professional association membership). If this continues there are considerable risks associated with practitioners with sub-standard or no qualifications or standards of practice, governed by no regulatory body (outlined previously in this submission). This situation poses real risk. There is no collection data around these forms of healthcare delivery. There is little sharing of important medical information, which poses a great risk (such as those associated with herb/drug & nutrient/drug interactions). This creates gaps in knowledge and understanding of our multi-faceted picture of health care in Aotearoa.

---

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
   X No
   □ Not sure

Comment:
There are Acts that deal with harm e.g. HDC Act 1994, ACC Act 2001, Medicines Act 1981 & employment related Acts. The HPCA Act should act to prevent harm through registration of all qualified health professions, title protection, scopes of practice & limitations, education requirements & monitoring, codes of conduct, ethics, prescribed use of scheduled drugs/herbs/dietary supplements by those trained in their risk, application & treatment use, health data collection, and to lead the way in cross-professional communication to support the development of an integrative health care system that is safer than that currently.

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:

Paramedics, nutritionists, herbal medicine & complementary & traditional medicine practitioners are not included.

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

☒ Yes
☐ No
☐ Not sure

Comment:

The numbers of RAs can be reduced to create more efficiency and reduce the costs to professional that are registered. Scopes of practice need to be clearly defined between professions. Modality specialties need to clearly delineated, with no confusion between them. There could be a flat fee for all practitioners, based on income earning potential.

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?
   X Yes
   ☐ No
   ☐ Not sure
   Comment:
   Cost reduction and prevention of duplication of work are the main reasons this should happen.

24. What is the ideal size of RA boards?
   Comment:
   Depends on the professions. Professions with similarities of approaches should be combined into one RA, with enough representation from the different professions to ensure that their voice is heard. Osteopathy, Chiropractic and Acupuncture and Chinese Medicine could be combined with the addition of Herbal Medicine, Naturopathy, Massage, Yoga Therapy and Ayurvedic Medicine, if and when those professions apply for registration.

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


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](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: Petrina Turner-Benny

<table>
<thead>
<tr>
<th>Address: (street/box number)</th>
<th>PO Box 13468, Johnsonville</th>
</tr>
</thead>
<tbody>
<tr>
<td>(town/city)</td>
<td>Wellington</td>
</tr>
</tbody>
</table>

Email: office@dietitians.org.nz

Organisation (if applicable): Dietitians NZ

Position (if applicable): CEO

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
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:

It is important that the Act is sufficiently flexible to accommodate the need for wider scopes of practice and the likelihood that in the future practitioners will work in increasingly diverse areas of practice.

The Act needs to require the Regulatory Authorities [RAs] to be more accountable for the disciplinary decisions that are made and the impact these have on the wider sector.

The RAs are an important conduit between the education, health and workforce sectors and the Act should be constructed in a way to enable these sectors to work more closely together. From 2013 the dietetic sector will have 3 accredited training courses graduating a minimum of 65 graduates. For the past three years the dietetic sector hasn’t been able to easily employ the 33 dietitians per year graduating from one course. Agreement by the RA to accredit new courses is only useful if decisions are made taking into account the health budget and future workforce planning needs.

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

Comment:
Not only high risk but also low risk professions should be brought under the Act. However the Act needs to be flexible enough to manage these professions accordingly.

Many sectors are now starting to train and employ health care assistants such as Dietitians Assistants and the Act should also be responsible for the regulation of these groups.

Dietitians NZ strongly believes that Nutritionists must also be regulated if the public is to be protected in the long term. People with very limited training in human nutrition currently advertise themselves as “Nutritionists” resulting in them having the opportunity to provide incorrect advice to members of the public with a chronic illness. Inappropriate advice on nutrition is also provided to the general public in gyms.

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:

Development and implementation of training such as this is expensive and as a result of cost constraints may result in an increase in fees.

It could be argued that training and professional development that sits outside the core requirements for meeting competency should be left to the professional bodies to administer.

In the event that the RAs are not consolidated we envisage that there will be unnecessary duplication of this type of training across professions.

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:
The Dietitians Board is currently in the process of updating the dietetic sector’s Code of Ethics with particular emphasis on Clause 4c which relates to the current constraints on dietitians to promote commercial products and services. The dietetic sector is completely divided on this issue.

A standard code may have merit if it was able to meet the needs of many professions but in doing this it would likely be diluted and not address the specific issues faced by individual sectors.

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
   - [x] Not sure

   **Comment:**

   The general public have a limited understanding of the Act and its role in regulating the health professionals that deliver services to them. The only time they are likely to be au fait with the Act is if they are involved in a disciplinary process.

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

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

   **Comment:**
The concern we have with the RAs having a mandated role in delivering pastoral care to health professionals is that this is in direct conflict with one of the core roles of professional associations. Whilst we respect that not all health professionals choose to belong to a professional association, we are concerned that there will be costs associated with duplicating this type of service and the model of “best practice” which professional associations are based on will be undermined. If the RAs carry out an increasing amount of pastoral care, we believe that there will be less reason for practitioners to belong to an association, particularly those in sole practice and this will contribute to their potential isolation.

However one area in which we do believe the RAs should play a prominent role is in the requirement for mandatory professional supervision of practitioners at all stages of their career. By this we mean a time set aside for “regular in depth reflection on practice that is facilitated by a trained supervisor”. Professional supervision has normative, formative and restorative functions. The restorative function is linked to pastoral care in that professional supervision has been shown to impact positively on increased job satisfaction, retention, psychological well being, perceived support and less perceived role overload and burnout. At present only newly graduated dietitians and those who have trained overseas and have recently emigrated to NZ must be supervised for up to a year.

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:

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:
9. Do we have the right balance of laypeople to health professionals on RA boards?
   √ Yes
   □ No
   □ Not sure
   Comment:
   
   The Dietitians Board currently has two lay people which is a good proportion of the total number of board members [7] that currently sit on the Board.

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:

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
☐ Not sure

Comment:

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:

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:

Mandatory professional supervision contributes to clinician’s professional development and increases accountability for ethical and effective practice.

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

√ Yes  
☐ No  
☐ Not sure

Comment:

In light of the increasing shift away from hospital based services and a move towards the delivery of care by practitioners in a range of new clinical settings, it is imperative that harm and serious harm are defined to ensure that the Act is able to be consistently enforced.

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:


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

   √ Yes
   □ No
   □ Not sure

   Comment:

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

   √ Yes
   □ No
   □ Not sure

   Comment:

   Whilst the core function of the RA is to regulate the sector to protect the needs of the public, this must be achieved in the context of what is affordable and feasible in the delivery of care. Lack of communication and consultation with employers and professional associations working alongside health professionals only serves to increase the barriers to the public receiving good quality care. Understanding the fiscal constraints on employers prior to the RA imposing additional requirements such as increasing in the cost of the APC will prevent such requirements from being self limiting.

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

   □ Yes
   □ No
   √ Not sure

   Comment:
Whilst Dietitians NZ understands the cost benefit of consolidating the numbers of RAs, we would be concerned if in doing this the specific nuances of various sectors were lost in the redesign, particularly for a relatively small sector such as dietetics. The benefit of having a Board that closely understands the sector it represents would seem to be more likely to protect the needs of the public.

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

The Dietitians Board currently has 7 members plus a Registrar. This is on the lower end of the optimum board size for efficiency and effectiveness. For most small professions, increasing the size of the Board to more than this would have a detrimental impact on the cost of the APC.

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

Submissions of

The Association of Professionals & Executive Employees,
The New Zealand Resident Doctors’ Association
&
The New Zealand Medical Laboratory Workers’ Union
HPCA Act Submissions
Health Workforce New Zealand
National Health Board, Ministry of Health
PO Box 5013
WELLINGTON 6145

26 October 2012

This document is a response to the 2012 Review of the Health Practitioners Competence Assurance Act 2003. The response is made on behalf of the Association of Professionals and Executive Employees (APEX), the New Zealand Medical Laboratory Workers’ Union (NZMLWU) and the New Zealand Resident Doctors’ Association (NZRDA).

APEX represents Medical Radiation Technologists, Sonographers, Psychologists, Anaesthetic Technicians, Physiologists, Physicists, Scientific Officers, Dietitians, Social Workers, Dental Therapists, Information Technology Specialists, Perfusionists, Pharmacists, Physiotherapists and Radiation Therapists.

The Review Paper has been distributed to all our members and there has been considerable dialogue as to the implications of various assertions, assumptions and suggestions made in the paper.

We have had considerable difficulty in formulating a response within the format contained in the Review paper i.e. with certain questions set out in the document and a request that these be responded to. We found much of the content of the body of the paper contentious, but the formulated questions did not allow us the opportunity to discuss those contentious issues. On other occasions the questions did not seem to us to relate particularly to the content of the Review paper. Much of our response therefore is necessarily a response to the content of the paper rather than the posed questions.

The response of our three organisations to the Review paper follows.
Executive Summary

We are of the view that no legislative changes are required for the following reasons:

1. The Responsible Authorities (RAs), in their current form, protect the skillsets of the professions they oversee, thus playing a highly valuable role in ensuring the safety and quality of the health system.

2. Medicine is becoming more and more complex and diagnostic tools ever more sophisticated. Our members work in professions where there are workforce shortages. Their professional skills need to be enhanced, valued and protected.

3. We anticipate an extensive lead time in before which the benefits of an enhanced primary care sector will be experienced in the secondary and tertiary sectors. In the interim the health sector needs RAs and our members to maintain the standard of quality in their professions.

4. Independence of the RAs is essential. The tension between operational expediency or budget constraints and the quality of care offered to patients present a conflict of interest for employers and it is this lack of independence that will make a standard-setting function impossible for an employer to perform.

5. If health practitioners are required to learn new skills to work in new ways (e.g. multi-disciplinary teams), or in new settings, this should not be at the expense of the expertise each profession is required by the RAs to have now.

6. Many of our members work in both primary and secondary settings now, demonstrating that the current RA structure is not a bar to such practices.

7. Working in isolated settings creates risk for both practitioners and public. Therefore the role of RAs in maintaining professional standards is even more vital.

8. Successful teams rely on members having particular roles and skills, and the other team members knowing what those are. The current function of RAs supports this type of role recognition.

9. Recruitment from outside New Zealand presents long-term problems and it is our view that it is a role belonging to the provider and employer, not a Responsible Authority.

10. The Review paper sets out a number of perceived difficulties with the current regulatory regimes, but the overriding impression we have is that the
difficulties are operational issues rather than difficulties that would warrant legislative or regulatory change. The problems/issues identified in the Review paper are all capable of resolution within the current legislative/regulatory regime.

11. The Review paper notes that the occupational regulation imposed by the Act carries cost. The HPCA Act/RA regulatory regime relies upon a high degree of self-regulation by practitioners and the professions and is much less regulated than other professions. It is our view that a continuum of different degrees of regulation, to reflect a continuum of different degrees of risk, would not be appropriate for the health practitioners we represent.

12. Solutions to the problems/issues identified in the paper could be found through more collaborative, consultative processes while maintaining the current legislative regulatory regime.
1 Future Focus

Workforce issues

At page 4 in the Overview section, the Review paper says:

To meet these challenges we need to shift away from a focus on hospital services and admissions to better, sooner, more convenient service delivery through the integration of primary care with other parts of the health service. Integrated care means better-coordinated health and social services and the development of care pathways designed and supported by the community, primary and secondary clinicians. It will deliver better-coordinated patient care across health service providers and professions and enable us to manage within tight fiscal constraints.

Delivering integrated care will require a more flexible workforce, where health practitioners will increasingly be required to work in a range of new types of clinical settings, in turn requiring access to a broader range of knowledge, skills and technology. They will increasingly work with multidisciplinary teams and will be part of clinically networked systems. A wider, deeper basis of commonality across health professions will be required.

Increasing integration of the health and disability system necessitates changes to education and training to ensure ongoing competency. It also means taking a wider focus that includes effective ways of working in teams, improved communication skills and support for consumers’ self-management.

Although regulation is generally managed along professional boundaries, those boundaries are increasingly shifting and becoming less distinct in increasingly complex clinical environments. Consumer care and the protection of consumer safety are increasingly dependent on how multidisciplinary teams and clinical networks operate. How well scopes of practice operate in the sector is also important, and in particular, how well they balance definition of practice with flexibility of clinical practice.

And at page 5, under the heading “Health practitioners working in teams”

Health professionals may be expected to work outside their professional context, to delegate work to members of other health professions, or to perform work that is not central to the regular work of their own profession.

Our members responded very strongly to these sections of the Review paper, challenging the assumptions upon which the statements are based.

Our members know that while change may be implemented to ensure greater integration with the primary sector, New Zealanders will still need the services
provided in secondary and tertiary settings. They anticipate an extensive lead time in before which the benefits of an enhanced primary care sector will be experienced in the secondary and tertiary sectors.

**Quality and safety concerns**

Whilst not a sole provider of patient safety in the health system, the Responsible Authorities (RAs) do provide a safety net below which standards should not fall. In doing so they ensure a quality of practitioner that, in turn, results in safer and better patient care than would otherwise have been the case. The standards of skills and knowledge among of our health practitioners inherently provide a safety net for patients; should this net be lowered so too would patient safety and outcomes. This, we would suggest, will increase cost to the sector through readmissions and adverse patient outcomes.

The Review paper states that rather than valuing the skillset that they can provide, the health practitioners must retrain in unspecified “broader” roles or perform work which is not central to the regular work of their own profession.

Our members are concerned that the professional skills they and their colleagues provide to the health system and the RAs' role in ensuring that those skills are maintained are not being adequately recognised by the Review paper. Their experience is that medicine is becoming more and more complex and diagnostic tools ever more sophisticated. Most of them work in professions where there are workforce shortages. Their skills need to be enhanced, valued and protected.

The Review paper by contrast promotes a “jack of all trades” approach, risking mastery of none.

We agree that the RAs do protect the skillsets of the professions they oversee, but we would assert that this is a highly valuable role in ensuring the quality of the health system. We tamper with that role at our peril.

Our members have communicated to us their concern that their workforces should not be “dumbed down”. The RAs set a minimum standard which every registered practitioner must meet. They are therefore setting minimum standards of quality. This system works because the RA governance bodies include senior members of the professions who understand what standards should be set. We believe they perform this role well.

**Independence is vital**

The RAs are independent. The DHBs and other health employers cannot fulfill this standard setting function as they are not independent. Health employers have drivers which are financial or which are not related to the quality of the professional health workforces. They are required to balance various demands of them (in the
case of the DHBs, the various requirements made of them by the Ministry in addition to the statutory requirements as set out in the New Zealand Public Health and Disability Act 2000).

There are occasions upon which health employers make decisions based on operational expediency or budget constraints, rather than the quality of the care to be offered to the public. We also see (and have experienced) health employers responding to political or cost considerations, with quality and safety relegated to a secondary consideration. An example of this would be if the Ministry were to promulgate a policy of "we want more health practitioners but we will accept less qualified practitioners" in an effort to meet the challenges that face the health sector.

The current system relies on the individual obligations imposed upon health practitioners to comply with the standards set by the RAs to ensure that the safety of the public is maintained. This is the bedrock of safe healthcare as provided to the New Zealand public and our members would be loath to see the RAs’ role tampered with or diminished in this regard.

**Working in isolated settings**

We appreciate that the Ministry has determined that the healthcare of the New Zealand public is best delivered by more integration with the primary sector, and this Review paper is based upon that premise.

We anticipate that if more health care is going to be delivered in primary settings or in multi-disciplinary teams, issues around potential isolation of health practitioners will arise. This could be geographical isolation; isolation because the health practitioner is working in a team in which they are the only practitioners of a particular profession e.g. the only physiotherapist on the team; or isolation because of the type of setting in which they are working e.g. a small set of rooms in a community setting.

We believe that more integration into the primary sector requires more stringent quality controls of health practitioners, rather than less. The more isolated a practitioner is, the more risk to the patient. For example this was found to have been a causative factor in the inadequate level of skill shown by Michael Bottrill when reading cervical smear tests. Primary care, even within the MDT setting, is and will continue to be more isolated than the more concentrated hospital-based setting. In this environment, independent maintenance of standards is even more imperative.

If health practitioners are to work in new clinical settings or in the community, health practitioners will increasingly be working alone or in smaller groups, or in multidisciplinary teams. We are also concerned at the prospect of losing the collegiality that we take for granted when health practitioners of the same
profession work together, where new skills, challenges or difficulties are discussed and shared with each other. If more practitioners are expected to work in isolated settings, more emphasis needs to be placed on ensuring that each such practitioner is working to a minimum standard, not less. The RAs ensure that this occurs by ensuring that those registered to work in specialist areas are appropriately trained and qualified, and continue to upkeep those skills.

Successful teams

We also asked our members about what multidisciplinary teams worked well and which did not, and what were the features of each type of team that caused them to work well (or not). Their unanimous response was that teams in which each member knew and performed their role in the team worked, and those within which there was not such clarity did not work well. It was also noted that poorly performing teams were extremely stressful to deal with.

Maintaining skills

We do not see RAs as inhibiting health practitioners' acquisition of new skillsets. RAs are able to collaborate and "cross credit" skills with the legislative framework we currently have. Further, they can ensure that the acquisition of these new skillsets compliments and augments the minimum standards that they expect of those who are registered.

Members also expressed concern that the maintenance of their current competencies could suffer. All our members are very busy at work, and many of them experience difficulties in making the time to ensure that their Continuing Education or Continuing Professional Development is allowed sufficient time to ensure their ongoing skill levels. The formality with which the RAs demand ongoing CE/CPD ensures that the practitioners and their employers make the time to attend to ongoing professional development. It is unclear as to how such ongoing professional and educational requirements would be met by the health system if practitioners are expected to broaden their skillsets.

Effects of loss of professional identity and collegiality

If health professionals are to be expected to work outside their professional context, to delegate work to members of other health professions, or to perform work that is not central to the regular work of their own profession, our members expect that this will mean:

- Risk to the public (for the reasons canvassed above);
- Loss of job satisfaction for health practitioners – they expect to feel that their skills have been devalued, and their workforce destabilised;
- Difficulties in maintaining competencies as described above;
- Worsening recruitment and retention problems for the health workforce; and
Succession difficulties – they ask who will teach incoming staff specialist skills if there are not already specialists employed. They also worry about a decrease in specialist numbers leading to an ever increasing burden being placed on those who are left.

Members also expressed concern about scenarios in which a few health practitioners with specialised skills would be expected to oversee the work of considerable numbers of lesser trained staff. They were concerned about the effect such a scenario would have on the job satisfaction both types of worker might otherwise enjoy.

The health practitioners we represent are intelligent, highly skilled professionals who derive a considerable amount of job satisfaction from a degree of self-determination, and a desire (and ability) to perform their role to a high standard. Many of them also derive collegial benefits from working alongside similarly trained, similarly skilled colleagues. They are concerned that this could be eroded.

**Recruitment of practitioners from outside New Zealand – allegation of protective practices by RAs**

“It is ... important that we can attract and retain both New Zealand and overseas-trained health practitioners.” The reviewers would like to look at how regulatory authorities can be restructured to deliver on these. “We need to ensure that the standards for entry and training decided by the RAs are set at the level required to ensure public safety, and not at a higher level that provides more economic benefits to the health professions than is warranted.”

Members expressed surprise at the implication that the RAs would set standards which provide economic benefits to the health professions more than “is warranted”. While we are aware of situations in which small groups of senior medical practitioners have been accused of anti-competitive practices, we are not aware of any cases in which the RAs have been implicated in such activities. If the Ministry is aware of examples, we suggest that these be made known so that a suitable response can be considered.

The paper appears to suggest the RAs have a role in recruitment and retention: they do not. That is the role of the provider and employer. To suggest that the RAs should be influenced by these workforce issues goes to the heart of our concerns: that standards could be manipulated for another purpose, in this case financial.

Relying on augmenting the New Zealand trained workforce with overseas trained practitioners is a short sighted 'solution' which has already impacted negatively on our ability to maintain a viable workforce. Taking healthcare workers from countries less well-resourced than New Zealand has ethical considerations that need to be addressed. Such a practice takes practitioners from countries that most need them in terms of their own population's health needs, but also these are countries
which can least afford to train the practitioners given their economic position. Standards of practice can be highly variable requiring the RAs to check, quite properly, whether the standards of the practitioner are appropriate, even if that does take some time.

Reliance on overseas trained practitioners also leaves New Zealand vulnerable to changes outside its control. Such changes could occur in the practitioner’s country of origin, or another country, for example, if an alternative place to practice became more attractive a place to work than New Zealand, or New Zealand became less attractive. For example, Canterbury DHB customarily relied upon 40% of their house officer positions being filled by UK graduates. After the Christchurch earthquakes UK graduates chose to return home, or not come to New Zealand at all. This seriously threatened that DHB’s ability to continue to deliver medical care.

The Review paper also identifies as an issue the time it takes RAs to work through their processes and make a decision as to registration, and the impact this has on both the applicant and the prospective employer. We would make the comments that should the sector develop new models of care which are different from the traditional professional skillsets and boundaries, healthcare practitioners from other jurisdictions will require training in these new ways of working, so that the time delay is likely to be lengthened.

Having said that, proper process must be given time to occur. The concerns of the employers as described in the Review paper highlights the potential conflict of interest that employers of health practitioners have. There seems to be little analysis by DHBs (and possibly other health employers) as to why they find it difficult to attract New Zealand trained staff and why they find it difficult to retain staff. Our experience is that there is rarely an examination of what they might have done to be a better, more attractive employer. Rather, they maintain the behaviours and attitudes that caused their recruitment and retention problems, and look to other parties to ‘blame’ or to solve their problems. In this instance the party to ‘blame’ appears to be attributed to the RAs.

Pastoral care

“Pastoral care also has an important role to play in retaining our health and disability workforce.” The reviewers suggest that the RAs could play a role in providing pastoral care.

None of our members could see any value in RAs providing pastoral care. We suggest they are too distant from the workplace to provide such in any meaningful manner.

Furthermore those who were in dispute with their RA were unlikely to seek pastoral care which came within the umbrella of the functions performed by the RA.
Is there a need to alter the legislation in respect of the role of the Responsible Authorities?

The Review paper notes (at page 3 of the Introduction, under the heading Principles to guide the review) that the Ministry is obliged to comply with the Government’s statement on regulation, Better Regulation, Less Regulation, which sets out the Government’s commitment to introduce new regulation only when satisfied that it is required, reasonable and robust.

The Review paper sets out a number of perceived difficulties (which may or may not exist) with the current regulatory regimes, but the overriding impression we have is that the difficulties are operational issues rather than difficulties that would warrant legislative or regulatory change.

Our considerable experience of the health sector is that the various entities and bodies which exist often work in silos, and are very poor at effective, honest communication. We believe that these difficulties or shortcomings identified in the Review paper are capable of resolution.

Many of our members are already working in both primary and secondary settings: physiotherapists, MRTs, social workers, RMOs (increasingly), psychologists all work both in their DHBs secondary services but also in community settings. They do so successfully within the current RA regime.

Section 1 of the Review paper identifies the following problems/issues (in summarised form):

- Acquiring the skills and flexibility necessary within the health sector to allow greater integration of primary care with other parts of the health service;
- Recruitment and retention of the health and disability workforce, including overseas recruitment;
- Effective, safe introduction of change (new procedures or models of care); and
- Ensuring inter-professional communication and collaboration.

At page 7, under the heading Increasing workforce flexibility, it is stated:

The HPCA Act provides an enabling environment in which RAs can increase the amount of commonality and standardisation across professional groups. The Act allows them to identify more generic skill sets that can help build better multidisciplinary teams, support expanded or diversified roles, and help simplify the process of health practitioners moving across to other workforce roles. The health sector requires this type of activity in order to develop a more sustainable and fit-for-purpose workforce.
It is intimated, but not clearly stated in the Review paper, that although the Act enables such activities, the view of the Ministry is that they are not being undertaken. If that is the case, then this would be another example within the health sector of the interested parties not working together effectively. The problems/issues identified in the Review paper and listed above are all capable of resolution within the current legislative/regulatory regime.

If the Ministry wishes to address the problems/issues identified in the paper, we recommend that more collaborative, consultative processes should be established to find solutions. We see no reason why the Ministry, RAs and the workforces themselves (and their representative organisations) could not work together in respect of each such problem or issue and strive to find mutually acceptable ways forward.

We do not believe new legislation is required.
4 Cost effectiveness focus

The Review paper notes that the occupational regulation imposed by the Act imposes cost. The HPCA Act/RA regulatory regime relies upon a high degree of self-regulation by practitioners and the professions, as is noted in the paper. This regime is much less highly regulated than other professions, for example lawyers and conveyancers, the insurance industry, or financial advisers and, as such, is a much less expensive a regulatory regime.

We agree that a lot more work would need to be done with the sector (including our organisations) if a more comprehensive risk framework is to be developed. However, given the example of a definition of a risk of harm¹ and a risk of serious harm (as developed by the Medical Council) provided in the Review paper, and the list of restricted activities already identified under the Act, we think it most likely that any of the members of our organisations would be considered ineligible for:

- A lesser level of regulation to reflect a lesser level of risk associated with their professional practice;
- Other forms of regulation would be sufficient to protect consumers from harm;
- Work-based supervision or oversight by more experienced professionals would be sufficient to protect consumers from harm; or
- Self-regulation as the sole means of regulation.

We doubt therefore whether a continuum of different degrees of regulation, to reflect a continuum of different degrees of risk, would ever be appropriate for the health practitioners we represent.

¹ Risk of harm may be indicated by:
- a pattern or practice over a period of time that suggests the doctor’s practice of medicine may not meet the required standard of competence; or
- a single incident that demonstrates a significant departure from accepted standards of medical practice; or
- recognised poor performance when local interventions have failed – this does not exclude notification of serious concerns where internal review or audit is inaccessible or unavailable to the person with the concern; or criminal offending; or
- professional isolation with declining standards that become apparent.

Risk of serious harm may be indicated by:
- an individual consumer may be seriously harmed by the doctor; or
- the doctor may pose a continued threat to more than one consumer and as such the harm is collectively considered ‘serious’; or
- there is sufficient evidence to suggest that the alleged criminal offending is of such a nature that the doctor poses a risk of serious harm to one or more of the public.
Review Submission
Health Practitioners Competence Assurance Act 2003

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?

The Act needs to support future innovation for the improvement of care and access to it. It needs to provide for public safety now and public safety in the future. It should enable RAs to set standards, scopes and prescribe qualifications that keep pace with what the sector needs in an environment that is undergoing constant transformational change.

This is also important in relation to our overseas counterparts and our ability to attract and retain health practitioners. The Act needs to enable us to keep pace with our international colleagues, to ensure NZ remains, or is viewed as, on par with the innovation and standards of other jurisdictions, and allows for the straightforward transfer of skills and talent between one jurisdiction and another (e.g. under the TTMRA). NZ may not always be able to offer the lucrative contracts some of the other jurisdictions can, but if everything else is on par with our overseas colleagues then the chances our attractive scenery and lifestyle will attract and retain overseas practitioners increases.

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

While the present need to protect the public from harm needs to remain a cornerstone of the Act, the requirement to maintain a scope entry point that reflects the most basic safe level of care stifles the transitioning of the workforce to innovation and change. We expand on this issue later in paragraph 25 (2) of the submission.

The Act can be used to promote a more flexible workforce to meet emerging challenges by broadening the purpose of the Act and enabling RAs to set more flexible scopes of practice. As mentioned above, the purpose of the Act should not just be about immediate public health and safety, but future protection through workforce planning and innovation.
Optometry is already becoming more flexible, with optometrist prescribers attempting to work more closely with ophthalmology and a few optometrists already working with medical professionals in a hospital/shared care setting. This flexibility will undoubtedly eventuate in the dispensing optician workforce assisting the optometry workforce in a similar way, allowing even greater flexibility of the two professions for the greater good of the public.

This flexibility will be enhanced by the upcoming amendments to the Medicines Act which will see optometrists able to prescribe glaucoma medicines; however, at present, the Act is restricting the Board’s ability to prepare for the future workforce needs of the public by only allowing the Board to prescribe qualifications that are necessary to ‘prevent harm’. We again elaborate on this issue further under question 25 in this submission.

Having overlapping scopes of practice between professions will relieve some of the public health access pressure, but such a move is breaking from the notion of traditional health care roles, which will inevitably take some getting used to. Even with changes to the Act to better support flexible scopes, ‘patch protection’ issues will still need addressing. While such issues cannot be dealt with under the Act, we believe it will be important for the Ministry of Health to support these sorts of flexible workforce initiatives by attempting to bridge silos and bring parties together for the greater good of the public.

In saying this, for these sort of initiatives and expansions of scopes of practice, the Act will first have to enable this by expanding the purpose of the Act from pure protection to current and future protection. In addition, as health practitioners will initially struggle with blurred boundaries and accountabilities where scopes overlap, it will be important for RAs to set clear guidelines for practitioners on how new arrangements will work and what is expected of them. All of this will be vital in ensuring open communication between practitioners and multi-disciplinary teams and quality and efficient handover of care, as well as creating a more sustainable and fit-for-purpose 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?**

Standards and capabilities in the diagnosis and management of eye disease have progressed dramatically in the last decade. By lifting the focus from just the prevention of harm towards an emphasis on developing standards of quality care that keep pace with the evolution of best practice, the HPCA Act will better enable the broader, more positive focus envisaged by this question.

4. **Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?**
There is already a lot of similarity between the standards of the different RAs, and policies and procedures are shared freely between the RAs. At present, the Act requires RAs to set standards of clinical, cultural and ethical conduct. There will always be points of difference that are profession-specific. It would be very difficult to have one set of standards for all, as you would also need profession-specific standards that would be an ‘addendum’ to the core standards.

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

No. It is very difficult to specify in the wording of a scope of practice exactly what duties each health profession performs for the public to be adequately informed about what they can expect. The standards set by an RA cover this, but not necessarily the scope of practice wording, and the Act doesn’t specify that the scope wording must inform the public, though you could argue that this is inherent in the Act’s purpose.

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

Board membership is tailored to providing competence and conduct review and remedial support or discipline where necessary. In our case, the professional associations provide an option for practitioner pastoral support. If the review creates regulatory responsibilities in this area then changes in resourcing and possibly membership will be necessary.

However, there is a very fine line between offering support and assistance and stopping someone from practising if they are unsafe. There is always a point at which public safety is the deciding factor, which means the relationship between the regulator and the practitioner can never be 100 percent collegial and supportive. Separation of duties needs to be maintained between health practitioner, employer and regulator to ensure the continued safety of the public.

There is also a fine line between the fair hearing of a complaint, disclosure to the consumer, and the effective rehabilitation of the practitioner. RAs are not the bodies responsible for receiving and investigating complaints in New Zealand. This is the role of the office of the Health and Disability Commissioner. Competence or health related matters referred to RAs by the Commissioner are done so to ensure the safety of the public in general, and are not referred with the intention that the specific complaint that lead to the issue be investigated by the RA. Therefore, processes that may proceed as a result are kept confidential between the RA and the practitioner, to foster trust and rehabilitation rather than to discipline the practitioner in response to the complaint, which would be the Commissioner’s (or rather the Tribunal’s) role, not the RAs role, where appropriate. Professional Conduct complaint matters are different to competence and health concerns, and the complainant is involved throughout these processes.
Most optometrists and dispensing opticians are self-employed or work in partnership with one another in small private practices. They are arguably at greater risk of needing pastoral care, as there are fewer parties working in association with these practitioners who can watch for early warning signs and offer assistance when needed.

We would support the establishment of a health practitioner ‘help’ phone line, where practitioners could call in, anonymously if preferred, to talk about health issues that could be affecting, or have the potential to affect, their practice of their profession, and receive advice from an experienced professional. This would be somewhat like the ‘Doctors Health Advisory Service (DHAS)’ that used to be in operation, but instead would be for all health professions. Such a service while beneficial, would be expensive to run, so funding, or at least part funding, by the Ministry of Health would be required.

Those providing the advice would need to be trained appropriately and know at what point to advise the practitioner they should be speaking with their employer and/or regulator about the health issue. A lot of encouragement would be needed for the health professions to feel comfortable using the service, but if privacy and anonymity were respected, it would not be long before trust in the service was built. If the practitioner was uncomfortable bring the matter to their regulator’s attention, this could be done by the phone service representative, and such a referral mechanism could be written into the Act if necessary.

Consumer focus

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

The Board’s challenge is to find the appropriate balance between the cost of regulation and protecting public health and safety. This Board’s strategy of competence assessment through CPD and random self audit is affordable with practitioner based funding but does not give the higher level of assurance of peer reviewed targeted CPD.

The Act involves consumers in decision-making to the extent to which it should in relation to the RA’s functions vs. those of the office of the Health and Disability Commissioner, as mentioned above. However, the Board acknowledges that broader decision-making, other than complaint/competence related matters, could benefit from consumer involvement.

The Board is interested in involving consumers more in its consultations and ensuring that consumers are better informed about the optometry and dispensing optician professions and what they can expect from them. This is an area that the Board has marked on its business plan for taking action on in
the near future and we would welcome any assistance or advice the Ministry might wish to provide the RAs on how this might be best approached and achieved. Our Trans-Tasman counterparts have just taken steps to progress in this area, so we anticipate they will also have some valuable advice to share.

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, information is readily available on RA websites and directly via contact with RAs and the HDC; however there is still confusion over the differing roles of the HDC and the RAs. This needs greater publicity. Even some practitioners are unclear on the distinction and who should be contacted about what.

The information readily available on websites about complaints processes and who to contact is perhaps not made use of as much as it could be for the simple reason that when it comes to complainants, they want to talk through what has happened with someone, so they reach for the phone first, which often eventuates in them being transferred from one organisation to another, i.e. employer to RA to HDC, resulting in no end of frustration.

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

Our Board is well served by two lay members because we currently have two highly skilled and committed individuals. This hasn't always been the case and is not guaranteed for the future. The current mix is working well for us and will continue to do so if recruitment standards are high and Board requests for retention are respected. The Board would welcome the addition of more laypeople to the Board. This would be in addition to, and not in lieu of, practitioner Board Members.

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, New Zealand should consider introducing consumer forums and we understand some RAs, such as the Medical Council, are already utilising these. As mentioned previously, such enterprises can be expensive, and it would be important for consumer forums across the professions to be at the same level of quality and effectiveness for the consumer and RA to benefit from it. Again, perhaps Ministry/government funding could be made available for this.
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?

No. The different legislations that have a role in protecting the public could definitely benefit from being more directly inter-related with one another and specifically stating the different roles of each within the legislations. The Health and Disability Commissioner Act 1994 and the HPCAA do this a little, but important legislations such as the Privacy Act 1993 and Health Information Privacy Code 1994 could interweave as well, as could some employer-related relevant legislation, though it would be important to recognise both the public and private employment settings in doing this.

There is a lot of segregation of duties with respect to protection of the public and who deals with what, e.g. the Privacy Commissioner, the HDC, the Accident Compensation Corporation (ACC), the employer and the RA etc. It can be very confusing for both the health consumer and practitioner, and means that people get shunted from one agency to another and will often give up before they get the answers they need. This is where it is important for each of these agencies to be in regular liaison about matters of common interest and to keep abreast of new developments or issues in the related areas, so that swift, knowledgeable advice can be provided to health consumers.

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

We do not have a comment on this. Our professions work largely in private practice.

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

Please see response to question 11.

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?

No, but these decisions have been made before a profession is approved for regulation. It might be helpful to reiterate this in the Act; however, it would need regular review in accordance with changes made to the criteria for a profession becoming regulated. Inclusion of specific risk of harm definitions in the Act would be beneficial. It would also be beneficial if these definitions aligned with those of other agencies, such as ACC.

Our Board would find clearer definitions helpful particularly in the case of the dispensing optician profession, that present a lower level of risk to the public than some of the other regulated health professions. It is often difficult to apply certain provisions of the Act and at the same time not generate
undue cost for members of the profession who might otherwise decide that
the cost of regulation is too high, which then presents a risk to the public.

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

See the comments for question 7.

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?

We do not have any comment to make with regard to this question.

Cost effectiveness focus

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

Cost is a factor in RA decision-making, but risk of harm is always the
overriding factor, and rightly so. There is always a fine balance to be struck
between the cost of regulation and the risk to patient safety, which is why RAs
tend to consult on more than just changes to scopes of practice, prescribed
qualifications and fees required by the Act. With health practitioner members
on RAs, RAs are acutely aware of the cost implications of decisions for
practitioners, and in turn on health consumers.

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

Yes it should, as mentioned earlier in response to question 14.

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?

Please see response to question 14.

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, however setting specific definitions of harm and serious risk of harm in
relation to the Act may assist in reviewing whether the right professions are
regulated under the Act and whether there are other professions not
regulated that should be.

It is difficult for health consumers to understand the difference between a
profession that is regulated and a profession that is not. Adding different
levels of regulation would make this yet more confusing for the health
consumer.
21. Could the way RAs administer their functions be improved?

Undoubtedly, and the RAs are always looking for ways to improve in this area and achieve cost efficiencies as a result where possible. There is a lot of variation between the RAs on how the different functions are administered, and this is in large part due to the differences between the professions, how long they have been regulated, and the resources available.

A distinction needs to be drawn at this point between improving the way functions are administered and achieving cost efficiencies. This question comes under the heading 'Cost effectiveness focus' and draws comparison with consolidations of RA secretariats in overseas jurisdictions. However, while efficiencies have undoubtedly resulted through the consolidation of secretariats, and would certainly occur in New Zealand were the same to be implemented here, this would not necessarily translate to cost efficiencies, and this has certainly not been the case in Australia.

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

It is our understanding that RAs consult widely with relevant stakeholders and not just on those matters the Act requires consultation on, as mentioned previously. The cost of such consultation does need to be kept in mind; however, the Board does agree that wide consultation is best to ensure that all points of view are considered in decision-making.

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

Perhaps, if after in-depth analysis the outcome suggested such a move would bring about efficiencies and cost effectiveness without sacrificing patient safety and profession-specific expertise.

24. What is the ideal size of RA boards?

Reductions in Board Member numbers has occurred in recent years and to varying degrees across the RAs. This has brought about significant change in the way RAs operate and has increased the commitment required of the remaining Board Members.

This Board is managing to operate with eight Board Members where there were previously 11, and it certainly would not wish to operate with any less than eight, particularly as it is regulating two professions and requires a fair number of each practitioner on the Board as well as laypeople.

The Board agrees with the advice given by the Council of Health Regulatory Excellence (CHRE) that boards in the realm of 8 to 12 members are associated with greater effectiveness, and believes boards should consist of no less than eight members to ensure each member has the time available to commit to the work involved.
25. Are there other issues you would like to raise?

There are two specific matters the Board would like to raise with respect to the review of the Act:

1. **The application of section 7(5) of the Act** -
   The Board considers that the penalty associated with breaching section 7 of the Act and misleading members of the public is insufficient to deter unregistered persons from claiming to be, and practising as, health practitioners, which puts members of the public at risk. The Board would like to see this review of the Act include consideration of revision to section 7, for the protection of the public.

2. **Current vs future harm & the TTMRA** -
   The Optometrists and Dispensing Opticians Board collaborates with the Optometry Board of Australia to fund the operation of an accreditation and examination service delivered by the Optometry Council of Australia and New Zealand (OCANZ). The shared purchasing of these services has provided a cost effective mechanism for the Board to meet its responsibilities under the Act in these two areas.

   Despite ongoing communication and collaboration between the Optometry Board's on either side of the Tasman, a gap between graduate level training of optometrists by Australian and New Zealand universities and the examination process maintained by the Council has been identified.

   University training standards have been responsive to both the advance of technology and legislation, and the Council has made adjustments to suit the Australian regulatory structure that includes a supervised scope to allow overseas trained practitioners to up-skill to local graduate standards while working in the community. The Board's legal advice indicates that the HPCAA provides no mechanism for supervised up-skilling to the same standard of skill and knowledge required of our own graduates unless **they represent a risk of harm**. While this is satisfactory for public safety at present, it impedes workforce preparation for the significant challenges in eye healthcare that Health Workforce New Zealand identified in its review.

   One of the principles of the TTMRA is that an occupation for which individuals may be registered in an Australian jurisdiction is taken to be an equivalent occupation to an occupation for which individuals may be registered in New Zealand. The Board believes that the Act should enable New Zealand to make changes similar to those being made in Australia where they make good sense and will be of equal benefit to New Zealand, to maintain equivalency of occupations between the jurisdictions. The Board therefore recommends that the purpose of the Act be expanded to allow for future protection through workforce planning and innovation.
An additional complication of the Board not being able to impose a similar supervised scope as that being imposed shortly in Australia, is that New Zealand will then become a back-door for overseas practitioners wishing to work in Australia. Under the TTMRA, Australia must allow New Zealand registrants to work in Australia in an equivalent occupation. Therefore, if they are able to work in New Zealand without being in a supervised scope of practice with conditions (aka notations) that require up-skilling, then they must be registered in Australia without that requirement as well. It is likely that these sorts of issues will continue to arise should our governing legislation not align, for the most part, with that of our Australian counterpart.
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: (name) Vanessa Cumming

Address: (street/box number) 55 Main North Road
(town/city) Geraldine 7930

Email: pickledlime@gmail.com

Organisation (if applicable): 

Position (if applicable): 

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
- [✓] Health Care Professional
- [ ] Other

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

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 encouraging delegated tasks under supervision that allow integrated patient care when they fall outside the scope of practice.

By supporting extended education and allowing revision of Scope of Practice. As an example look at the Scope of Practice of a FBDO member, (ABDO qualified). This should be the benchmark of education for Dispensing Opticians.

IE: refraction: patient has just been seen by Ophthalmologist or Optometrist. By allowing a Dispensing Optician to complete the new refraction the optometrist's time is better served by completing pathology which in turn frees up access for other patients for the correct and appropriate care.

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 encouraging and up-skilling educational programs that cater for Scope of Practice overlap.

It would be prudent to look at ABDO (Association of British Dispensing Opticians) and how they have achieved a wider scope of practice. This is not forging new ground but is a beneficial system for all professionals involved.
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: By promoting an integrated approach between Ophthalmologists, Optometrists and Dispensing Opticians for the best outcomes for patient care. This would allow a more flexible workforce.

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: All health care professionals should abide by the same code of conduct and ethics and common learning across the entire health care sector.

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: There needs to be a simple form of public access to the required information of what they can expect from a health practitioner which relates to scope of practice.
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:

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:

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:

Easily found on the website, we don’t hear of many complaints but the process is certainly there to be followed if required.
9. Do we have the right balance of laypeople to health professionals on RA boards?

☐ Yes
☑ ☐ No
☐ Not sure

Comment:

As a shared RA Board between Optometrists and Dispensing Opticians we need equality! 2 lay people, 2 Optometrists & 2 Dispensing Opticians, removing 2 Optometrists, providing a balanced RA. Dispensing Opticians will never be heard with the current imbalance.

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:

Absolutely there should be a public forum that feeds into the RA with matters of concern.

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
☐ Not sure

Comment:

Corporate employers may be inclined to put commercial decisions ahead of risk management.

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:

In our profession we believe the legislation covers the required level of safety.

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:

By the continued endorsement of the existing act
IE: Continuing Professional Development

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:

I am unaware of any requirement of RA’s to consider the cost impact.

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

☐ Yes
☑ ☐ No
☐ Not sure
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:

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  ☐ No  ☐ Not sure

Comment:
As a shared RA Board between Optometrists and Dispensing Opticians we need equality! 2 lay people, 2 Optometrists & 2 Dispensing Opticians, removing 2 Optometrists, providing a balanced RA. Dispensing Opticians will never be heard with the current imbalance.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   ✔  Yes
   ☐  No
   ☐  Not sure
   Comment:
   Particularly when Scopes of Practice are extended and delegated tasks are considered.

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:
   The size should reflect the Scope of the Health Care Provider. O&DO Board should provide an equal number of professionals, IE 2 Optometrists, 2 Dispensing Opticians and 2 Laypersons. Therefore there is no imbalance and no one profession pushing their own agenda or controlling another Professional Health Care Provider.

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

We would encourage the need for there to be a process that allows a Health Care Professional, or Association, to have access to a mediator if there is conflict with an RA.

We would like to see a process put into place where we have the right to appeal a decision put into place by the RA. Where do we go if we believe the person doing an assessment on our education is not qualified to make the decision. Or the person assessing is biased. Etc.

If a RA is shared by two professions there should be equality, no one profession should outnumber the other profession. Particularly looking at the O&DO Board. 2 Optometrists, 2 Dispensing Opticians and 2 Laypersons. Providing equality to both Professional Health Care providers.
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: Peggy Savage

Address: 39 Carey Street

Waitara

Email: sav.pj39@xtra.co.nz

Organisation (if applicable):

Position (if applicable): Dispensing Optician

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

X ☐ 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?

X ☐ 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 addressing tasks that fall outside the scope of Practice, with a view to allow delegates tasks to commence under supervision

Eg refraction – once cleared by an Ophthalmologist after cataract surgery, a Dispensing Optician could refract. When receiving a prescription from another source, and this falls outside the requirements (eg +0.75 add when safety spex start at +1.00 add) these example free up the Optometrists for using their time more pathology and better use of their chair time

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

Comment:

For the up-skilling of practitioners educational programmes that cater for Scope of Practice overlaps

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?
When considering the best outcome for patient care, an integrated collective approach between Ophthalmologists, Optometrists and Dispensing Opticians working together would allow for a more flexible workforce.
Eg Post cataract surgery, once the Ophthalmologist has seen patient for final check the Dispensing Optician could refract.

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:
I believe that all health care professionals should adhere to the same code of conduct, ethics and common learning across the entire sector.

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:

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

☐ Yes
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:

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:

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

☐ Yes  ☑ No
As a Dispensing Optician, we have a shared RA Board with Optometrists, and these is an imbalance as the Optometrists have more persons on it. I believe it should be of equal numbers eg 2 lay persons, 2 optometrists and 2 dispensing opticians – this would be a balanced RA.

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:
I believe there should be a public forum that gathers matters from the public and relays them back to the RA.

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
   Not sure
Comment:

A large corporate employer may be leaning towards financial decision making ahead of risk management

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:
   
   Currently, the legislation covers this level of safety in our profession

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:
The act covers this with continuing professional development and I believe this should be 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
   - [x] 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:
   - Is this part of their role?

18. Should the HPCA Act define harm or serious harm?
   - [ ] Yes
   - [x] No
   - [ ] Not sure
   Comment:
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?

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

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?

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

Comment:

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

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

Comment:
By providing equality to both the Dispensing & Optometrists by having an equal number of representatives in the Board.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   
   Yes [x]  
   No  
   Not sure  

   Comment: When and if the Scope of practice is extended and delegated tasks are being considered. Also, when an educational programme is being considered for registration & qualification.

23. Should the number of regulatory boards be reduced, as in the UK?
   
   Yes  
   No [x]  
   Not sure  

   Comment: 

24. What is the ideal size of RA boards?
   
   Comment: This should be determined by the scope of the Health Care Provider.

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

I believe we have the need for access to a mediator if there is a conflict with the RA as there is no process for this.

If a RA is shared, there should be equality by all professions with equal numbers, as not profession should outnumber another.