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: Helen Little and Jane Elmslie  
(name)

Address: Private Bag 4710  
(town/city) Christchurch

Email: Helen.little@cdhb.health.nz. Jane.elmslie@cdhb.health.nz

Organisation (if applicable): CDHB

Position (if applicable): Dietitians

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  
- [ ] Academic/research  
- [ ] Pacific  
- [ ] Education/training  
- [ ] Provider  
- [ ] Non-government organisation  
- [ ] Professional association  
- [x] 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 The summary will include the names of all those who made a submission, unless individuals request that their names not be published. 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?**

- [x] 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 ensuring scopes of practice are clear between the different professional groups under the HPCA Act.

Care and service models need to be clear about each discipline’s scope of practice especially if some professions are regulated under the act but others are not for example Dietitians and Nutritionists.

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

Comment:

To promote multidisciplinary collaboration by ensuring scopes of practice are clear between different professional groups so that each professional group understands the others’ roles.

Multidisciplinary collaboration can reduce repetition and reduce waste if different health professionals can share aspects of their roles that are similar. For example health professionals assessing a patient at home may use the same assessment tool and work as a team to provide the care required rather than working as individual health professionals but recognising when specific professional tasks are 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?

Yes

Comment:
Joint training initiatives where possible are recommended. For example, all professions under the HPCA Act who are required to have cultural competency should have the same requirements and therefore make training across all the professions possible. This would help to improve communication between health professions groups.

The HPCA Act could be clearer about what disciplines are required in Health settings and the composition of multidisciplinary teams.

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:
Yes it would be good to have an overarching standardised code of ethics and common learning across 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

Comment:
No it not clear particularly for Dietitians. The distinction between registered Dietitians vs. Nutritionists is unclear and confusing for the public. Information to inform people regarding the difference between these professions is lacking and the HPCA Act only regulates one of these professional groups.

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:
   It is unclear how this would be carried out but it is worth considering. An example of pastoral care from the Dietitians Board was evident following the CHCH earthquake. At that time they delayed the health professional requirements to complete their APCs; this was greatly appreciated by the Dietitians in CHCH at the time.

**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:
   No as not all disciplines are covered by the Act and therefore are not regulated.
   If scopes of practice are broad therefore there is potential for consumers to be confused regarding roles of different professions. This makes consumers vulnerable to misinformation as they do not know who to believe.

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:
Unsure and not aware that this information is publically available. Not sure if the public would know where to obtain this information.

Patients making complaints would usually do so via the employer or via the Health and Disability Commissioner and not sure if they would know how put a complaint regarding a practitioner to the RA's.

9. Do we have the right balance of laypeople to health professionals on RA boards?
   √ Yes
   ☐ No
   ☐ Not sure
   Comment:
   But it is important they have no conflict of interest

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:
    Yes it would assist NZ to introduce consumer forums but this has to be balanced against any increased costs that may accrue as a result.

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:
It is complex and there are many laws involved. The interface between the different relevant legislation needs to be carefully considered.

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:

The Employment Relations Act is important to ensure health professionals employed in specific roles are not asked to perform roles outside their scope of practice or given unrealistic expectations of the roles and responsibilities in their position.

More coordination and understanding of roles and scopes of practice are required by employers.

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:

Not sure

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
- [x] No
- [ ] Not sure
Comment:

Better definition of scopes of practice as they can be unclear and open to interpretation. Better pastoral care of private practitioner’s e.g. mandatory mentoring system.

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

More engagement with statutory boards and with professional organisations is required and this will require judicious application. See also 14 above.

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:

More clearly defined roles of each discipline would help and a better understanding of issues faced by each group. Long term harms and risks, such as nutritional deficiencies, are not dealt with well by the Act at the moment.

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:

Probably not they are too lax.

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

√ Yes
☐ No
☐ Not sure

Comment:

Co-operation is a good idea as this will promote understanding between professions and hopefully reduce costs.

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

√ Yes
☐ No
☐ Not sure

Comment:

Yes but his may increase the workload of smaller professions.

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 have no further comments.
Scopes of practice need to be clearly defined
Require more dialog between training schools, employers and R.A.'s
Commerce Commission submission on the 2012 review of Health Practitioners Competence Assurance Act 2003

Purpose

1. This submission sets out the Commerce Commission’s views on the Health Practitioners Competence Assurance Act 2003 discussion document. Our comments focus on how competition can help deliver the Ministry of Health’s objectives of providing a framework that supports workforce flexibility, and help match the level of regulation to the level of risk of harm to the public.

2. The Commerce Commission wants to encourage pro-competitive behaviour as a mechanism to help enable efficiencies and innovation in the health and disability sector, and assist the health sector to continue to implement new service delivery models.

Recommendations

3. The Commission recommends that, in its review of the Health Practitioners Competence Assurance Act 2003 (HPCA Act), the Ministry of Health:

3.1 introduces a monitoring regime to ensure that standards set by regulatory authorities (RAs) are objectively justifiable and transparent; and

3.2 adheres to the principles for developing or reviewing scopes of practice that came out of the 2007-09 review of the HPCA Act.

The role of the Commerce Commission

4. The Commerce Commission strives to achieve the best possible outcomes in markets for the long-term benefit of New Zealanders. We aim to make markets more competitive and consumers better informed. Competition delivers lower prices, better quality, more choice, and greater innovation to New Zealand consumers.

5. The health and disability sector is currently a focus area for the Commission. We want to work with service providers in the sector to improve awareness of, and promote voluntary compliance with, competition and consumer laws.

Principles for developing or reviewing scopes of practice

6. Where professional bodies are responsible for the setting and enforcing of standards and rules, the opportunity for anti-competitive conduct or effects can arise. Self-regulators set standards to protect public safety but these standards must not be unduly high and should be objectively justifiable and transparent.
7. We consider that there should be a process to ensure that standards and rules set by RAs are objectively justifiable and transparent. It is likely that independent review or oversight is needed to ensure a robust outcome. From a competition standpoint, expanding the scope of practice in a profession is favourable when it can be done safely and effectively. Expanding scopes of practice benefits consumers by increasing the range and choice of services and providers. More overlap between scopes of practice intensifies competition between providers, and provides greater workforce flexibility, putting downward pressure on prices and increasing the likelihood of service improvements and innovation.

8. We strongly support the principles for developing or reviewing scopes of practice that were suggested after the 2007-09 review of the HPCA Act:

8.1 defining scopes to protect public health and safety rather than responding to professional preferences;

8.2 defining broad scopes to enable as much workforce flexibility as is compatible with protecting public safety;

8.3 setting qualifications that are the minimum requirements for public safety;

8.4 allowing for movement between scopes by, for example, recognising the relevance of prior learning;

8.5 consulting widely and openly without predetermined positions, and carefully evaluating and responding to submissions; and

8.6 basing decisions on the best available evidence, including from other professions, especially where scopes of practice overlap.

9. The Commission considers that scopes of practice set with these principles in mind are unlikely to be used in an anti-competitive way.

**Balance between competition and safety**

10. We recognise that regulation in the health sector involves a balance between competition and the safety of the public. The trade-off between the two comes into play when setting entry requirements to a profession, setting overlapping scopes of practice, restricting advertising, and restricting elements of pricing.

11. The consequence of getting the balance wrong, and setting standards higher than necessary to protect the public, is that barriers to entry and movement between professions in the sector will be too high. Barriers that are too high could prevent entry, suppress innovation, and result in higher prices. Overly restrictive standards, particularly those related to advertising and pricing, can also limit the extent to which health practitioners compete to provide quality health services at a good price.
Overly restrictive standards

12. The HPCA Act discussion document states that the Commerce Commission maintains an interest in ensuring the standards set by the RAs do not impose a greater barrier to entry than is required to protect the public. The Commission is often not in a position to judge whether the professional standards set by the RAs are too high. However, we do maintain an interest in whether the standards are being used anti-competitively, to keep out competition rather than to ensure safety.

13. Standards that are higher than necessary could be restricting entry or sideways movement by professionals who could stimulate competition in the market. This could be the case when standards of entry to a profession, including those related to professional requirements, are higher than they need to be, keeping out professionals who are qualified to perform the work. Or it could be the case that inflexible scopes of practice do not allow certain procedures to be performed by professionals who have the necessary skills and qualifications to perform them.

14. Restrictions that may place undue limits on competition include restrictions on elements of advertising or on pricing. We would prefer that restrictions to advertising not go beyond prohibiting false or misleading representations. Further restrictions can limit consumers’ access to information that benefits competition. Additional restrictions that go beyond those that prohibit false or misleading representations should be clearly linked to a reduction in consumer harm. In regard to pricing restrictions, restrictions on discounting, for example, could be viewed as an agreement that controls an element of a price, which is considered price-fixing, and is deemed to be anti-competitive under the Commerce Act.

Anti-competitive agreements

15. Health professionals are increasingly being required to adopt new models of service delivery in response to the Government’s focus on more integrated models of care. This requires a greater degree of collaboration among providers, which can lead to business opportunities, but may also present risks under competition law.

16. Agreements between competitors that substantially lessen competition in a market are illegal under the Commerce Act. Medical professionals have been prosecuted for entering into anti-competitive arrangements in the past. For example, the Ophthalmological Society of New Zealand and five individual ophthalmologists were prosecuted for entering into anti-competitive arrangements that were designed to prevent or hinder entry into the market. In Australia, two cardiothoracic surgeons were prosecuted for taking action to hinder or prevent another surgeon from gaining accreditation at a private hospital in Adelaide, and obtaining appointments at various hospitals. Further details of these cases can be found in Attachment A.

17. Medical professionals are liable under the Commerce Act for anti-competitive agreements entered into by medical colleges, societies or associations of which they are members, whether or not they were aware of the agreement.
18. The consequences of breaching competition law are significant and are likely to be strengthened if a bill proposing criminal sanctions for certain types of anti-competitive agreements is enacted. The bill has received multi-party support, and could pass into law as early as 2013.

19. In certain cases, anti-competitive agreements, even among competitors, may not be illegal under the Commerce Act. Agreements can also be authorised – the Commission is empowered to grant an authorisation if it is satisfied that the public benefit of the agreement outweighs the detriment arising from the loss of competition.

**International experience**

20. The Commission notes that the National Health Service in the United Kingdom has released principles and rules for cooperation and competition for those who commission healthcare services, and for the providers themselves. The principles include directions to promote patient options, and to ensure that patients have accurate and reliable information so that they can exercise more choice and control over their healthcare. Providers of health care and those who commission them are also advised not to reach agreements that restrict commissioner or patient choice against patients’ and taxpayers’ interests.\(^1\)

21. The Canadian Competition Bureau conducted a market study in 2007 with an objective of increasing awareness within the professions of the importance of avoiding unnecessary restrictions on competition.\(^2\) A post-study assessment published in 2011 concluded that it had been effective in accomplishing this objective. A summary of the changes made to the optometry profession are a good example of significant progress toward the elimination of restrictions on competition, which has allowed for greater workforce flexibility.

21.1 Practice restrictions on optometrists have been, or are in the process of being, reduced in British Columbia, Ontario, Nova Scotia and Prince Edward Island, to give optometrists new authority to prescribe pharmaceuticals for eye conditions that they are qualified to treat.

21.2 Opticians in British Columbia have been given authority to perform eye tests on individuals, subject to being certified to perform the tests, and to the implementation of a screening process to identify persons requiring more in-depth assessment by an optometrist.\(^3\)

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\(^1\) National Health Service System Management and New Enterprise Division, “Principles and Rules for cooperation and competition”, 30 July 2010.


22. Similarly, the Canadian Competition Bureau reports that a number of provinces are in the process of creating pharmacy technician designations that would allow pharmacy technicians to perform dispensing tasks currently reserved for pharmacists.\textsuperscript{4}
Attachment A

The southern ophthalmologists

1. This case study looks at the Commerce Commission’s case against the Ophthalmological Society and five ophthalmologists under section 27 of the Commerce Act.

2. Southland Health had a long waiting list for routine cataract surgery and received extra government funding to clear the backlog. At the time, there was only one ophthalmologist in the area. He was not prepared to do the surgery below his usual fee. Southland Health consequently entered into negotiations with two Australian ophthalmologists.

3. The local ophthalmologist objected to Southland Health hiring the two Australian ophthalmologists, and claimed they would be placing his patients at risk by performing surgery, then leaving the country. He and a number of other South Island-based ophthalmologists came to an arrangement that they would not provide the professional support required by the Australian ophthalmologists, nor the oversight required by legislation for one of the ophthalmologists, which was acknowledged as being “largely a formality” in this case.5

4. As a result, the Australian ophthalmologists withdrew their proposal to carry out the surgery.

5. The High Court found the defendants had reached an arrangement or understanding to oppose the Australian ophthalmologists undertaking the surgery in breach of section 27 of the Commerce Act. It further found that the purpose of the arrangement was to oppose entry by the Australian ophthalmologists and therefore to prevent competition from ophthalmologists outside the region who did not have the support of the local ophthalmologist.

6. The Court found that the arrangement had the effect of substantially lessening competition in the market for cataract surgery in Southland. Prices for cataract surgery fell significantly with the prospect of competition. This, the Court found, showed that entry by either of the Australian ophthalmologists would have stimulated increased competition, with benefits to Southland Health’s patients.

7. The arrangement created a barrier to entry that entrants who had the local ophthalmologist’s support did not face. It prevented the Australian ophthalmologists from entering the market, and reduced competition relative to what would otherwise have occurred. The effect on competition was likely to last for 18-24 months and this was one of the reasons the Court considered a substantial lessening of competition to have occurred.

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5 Commerce Commission v The Ophthalmological Society of New Zealand Incorporated & Ors [2004] 3 NZLR 689 (HC) at [88].
The South Australian cardiothoracic surgeons

8. The Australian Competition and Consumer Commission (ACCC) took proceedings alleging that two cardiothoracic surgeons had engaged in anti-competitive conduct over the provision of cardiothoracic surgical services to private patients in or near South Australia.

9. The Federal Court decided that the surgeons had made an arrangement that they would hinder or prevent a newly qualified surgeon from entering or supplying his services in the market before he had undertaken further surgical training, despite the fact that he was legally qualified to practise as a cardiothoracic surgeon.

10. The court also declared that the surgeons gave effect to the arrangement by advising either hospitals at which the surgeon sought to operate, or cardiothoracic surgeons who had been asked to support the surgeon's applications to operate at those hospitals, that the surgeon was insufficiently trained, or had not completed his training, and should not be allowed to operate at those hospitals.

11. The court also declared that both of the surgeons individually attempted to reach non-compete arrangements with a third surgeon whereby that surgeon would not provide surgical services at one hospital and the individual surgeons would agree not to provide surgical services at another hospital.

12. The court ordered penalties and a contribution to the ACCC's costs against both surgeons. They were also required to attend competition law compliance training.
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# 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:  
Aileen Derby / Jill Parker

Address:  
SSU, Waikato DHB, Private Bag 3200  
Hamilton 3240

Email:  
aileen.derby@waikatodhb.health.nz

Organisation (if applicable):  
New Zealand Sterile Services Association (NZSSA)

Position (if applicable):  
President NZSSA

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

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**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:

| Clearer criteria for applicants / organisations wanting to become registered under the Act |

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?
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:

Educate public on their rights within the health sector. Encourage the public to ask health professionals more questions about the care they receive. Encourage the public to voice their concerns regarding the care they receive(d). Enlist feedback from the members of organisations on what education they require other than what they currently receive.

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:

Define in clearer terms what a health profession is?

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:

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:

There could be more promotion of what is happening by use of other media not just the MOH web site

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: 
This is a good method of assisting consumers / public to communicate any matters with 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:

If professions are not meeting the criteria for regulation, but still pose some risk to the public from activities not directly involved with the patient/client, employer based risk management should play a role. Self regulation by professions is also a good way, but these bodies need to have some power to ensure practitioners are registered with them and are keeping practices/skills up to date and safe for the patient.

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:

More consultation with the respective organisations on the risk posed by their profession if they don’t get it right and what level of regulation they should have.
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:
   Should be a consistent approach to identifying harm or serious harm in the health sector.

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
   Comment:

21. Could the way RAs administer their functions be improved?
   ☑ Yes
22. Should RAs be required to consult more broadly with relevant stakeholders?
☑ Yes
☐ No
☐ Not sure
Comment:

Communication is key to understanding each others viewpoints.

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:
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) Sue Ineson

Address: (street/box number) PO Box 10233
(town/city) Wellington

Email: cmc@populationhealth.org.nz

Organisation (if applicable): Council of Medical Colleges – the umbrella organisation for 14 Medical Colleges in NZ – this submission is on behalf of eight of our members.

Position (if applicable): Executive Director

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) .............................................................................................................................

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☐ Provider ☐ Funder
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Submission on the 2012 review of the Health Practitioners Competence Assurance Act 2003 (HPCA Act)

By the Council of Medical Colleges (CMC)

This submission is sent on behalf of eight Member Colleges of the CMC who broadly support the points made in this joint CMC submission. Some Colleges will also be making their own, independent submission with emphasis on other points of importance to their particular College.

Introduction

The Council of Medical Colleges in New Zealand (CMC) is the collective voice for the Medical Colleges in New Zealand and through its members, provides a well trained and safe medical workforce serving the best interests of the New Zealand community.

CMC brings together 14 member Medical Colleges who provide support to over 7000 specialist medical practitioners working in a range of 35 specialties in the New Zealand health system. The Medical Colleges themselves are not-for-profit, educational bodies responsible for the training and examination of medical practitioners. The Medical Colleges advise on workforce issues and advocate for appropriate health quality services in New Zealand. They also advise the Medical Council of New Zealand in relation to standards for training and qualifications of specialist doctors from overseas and provide programmes of continuing medical education or recertification as defined by the (HPCA Act).

It is noted that the time line to respond to this review is short, which limits input as it takes time for the Colleges to consult their constituency groups and prepare a submission.

In addition notice about the HPCA Act consultation meetings was inadequate as demonstrated by low attendance in Wellington.

It is also noted that the issues and questions in the separate sections of the submission document overlap and are not always aligned which makes response difficult. Therefore this submission addresses the issues rather than answers all the questions and CMC comments may apply to more than one section of the consultation document.

It is also noted that many of the points raised in this document were noted in the 2008 HPCA Act review and that a more thorough implementation of those recommendations at that time may have enabled this review to address other issues and have the information to assess the efficiency and effectiveness of the Responsible Authorities (RAs).

Overall comments

This response to the HPCA Act review primarily addresses issues that impact on CMC’s members and their constituencies, that is the impact on vocationally registered or specialist doctors and doctors in specialty or vocational training.
CMC does agree with many things in the scope document such as the following:

- Focus the sector towards better, sooner, more convenient service delivery through the integration of primary care with other parts of the health service and to retain a workforce that delivers services within a lower growth funding.
- Improve pastoral care for the health and welfare of health professionals and support for the sustainability of the workforce.
- Improve/ develop cross sector data collection systems to inform sector intelligence and planning.

However, CMC does not see that a change in the HPCA Act is needed to deliver on all these principles and many of the matters suggested may take emphasis away from the purpose of the HPCA Act.

CMC notes that the main purpose of the HPCA Act is to “protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions”.

To enable this purpose to be met, the mechanisms regulators use are to:

- Assess who gets onto the register - ensuring those that are registered are fit and competent to work.
- Assess who stays on the register so the public can trust that those on the register are able to practise safely and maintain their competence.
- Agree on who are removed from the register for long or short periods because they have shown to be wanting in competence, or have been practising below the required standard or are not able to practise due to ill health.1

Therefore the HPCA Act (in common with similar health professional and occupational regulation world-wide) is essentially about regulation of the individual for public protection.

This relatively limited role is supported by other legislation and regulations within the sector and by employment contracts and by a myriad of guidelines and standards in health which set other standards and ways of working for those providing services in the health sector.

The consultation document seems to be suggesting a move away from the clear purpose of the HPCA Act but there is little evidence in the consultation document:

- To indicate that the concerns or issues raised are caused by the HPCA Act.
- On how changes in the HPCA Act could lead to improvements in the working of the health sector.

The emphasis of the HPCA Act must be on safety, prevention and competence.

While operation of the HPCA Act and operation of the responsible authorities (RAs) can be improved, CMC’s perspective is that HPCA Act is currently achieving its purpose and a rationale for radical change has not been given.

1 Thompson, E. Understanding medical regulation – a guide to good practice. HLSP Consulting 2005
1. Future focus

1.1 Workforce development and the purpose of the HPCA Act

CMC supports the current HPCA Act functions which require the Medical Council (and other RAs) to set the standards for educational, training and competence for safe practice; that is assess who is safe to include on register and assessing who is competent to stay on the register.

Sections 13 (a), (b) and (c) of the HPCA Act already note that the “standard to be set” by the RA is to protect the public, and not to unnecessarily restrict registration or impose undue cost on applicants for registration. Therefore the HPCA Act sets a safe standard not a “gold standard”.

CMC does not accept that it is better for the public to have a “doctor of a lesser standard” than not to have a doctor, as the former gives the public unsafe expectations.

Therefore as standard setting bodies, the RAs cannot then “develop” or “increase” the workforce as this function conflicts with their standard setting role. Workforce numbers could be increased by lowering the acceptable standard but this would conflict with the purpose of the HPCA Act to “protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions”.

Planning and achieving workforce development is the role of other groups including that of Health Workforce New Zealand (HWNZ).

1.2 Health practitioners working in teams

The HPCA Act has a focus on the competence on the individual practitioner but this does not mean that the role of the practitioner cannot change and the HPCA Act framework cannot support workforce flexibility and working in multidisciplinary teams.

Effective multi-disciplinary teams and flexibility cannot be regulated for by a statute. Health teams are diverse in size, function and structure and are dependent on the specific health setting and the employment situation. Good teams function where there is the right environment and culture supported by management: not because of legislative requirements.

Currently in medicine and within the HPCA Act, team work is already supported because:

- The Colleges include education and training about team-work and communication as an integral part of their specialty training programmes. There is explicit guidance on working within teams in the RA documents of standards expected of the health professionals regulated by the HPCA Act. In medicine it is supported by the Medical Council’s standard setting document Good Medical Practice.

Other sector documents encourage team work such as:
• The Code of the Health and Disability Commissioner (HDC) which states that “every consumer has the right to co-operation among providers to ensure quality and continuity of services” and breach of the Code can be acted on by the HDC or the Medical Council.
• Employment contracts and expectations of most health providers.
• The work and commitment of the majority of health professionals.

CMC recommends that a more explicit focus on inter-professional communication and collaboration could be introduced into the HPCA Act:

• By adding to the functions of the RAs in Section 118(j) by requiring RAs: to liaise with other authorities appointed under this Act about matters of common interest including setting scopes of practice that do not limit integrated models of care or intra-professional cooperation and that encourage team work.

1.3 Scopes of practice

The consultation document indicates there is a breakdown in cooperation between some team members due to concerns about practitioners rigidly adhering to defined scopes of practice. This leads to a lack of flexibility in the workforce. However there are no examples of these practises in the document.

Scopes of practice do and have always overlapped. As the sector has grown and developed new scopes, new areas of work and new roles are continually being developed. This should continue.

Scopes have been developed primarily for the professions and the providers to identify the health service being provided and health services that the practitioner is permitted to perform, subject to any conditions imposed by the responsible authority. The public require a different level of information.

1.4 Information in scopes of practice and workforce flexibility

CMC recommends that, following this review of the HPCA Act, all RAs are requested to review their scopes of practice with wide sector consultation, within a template supplied by the Ministry of Health (so that there is not the current disparity between lack of detail/excess detail).

When scopes were originally introduced under the HPCA Act in 2003/4, there was little experience with the concept and although the sector was consulted about the scopes as required by the HPCA Act, there was very little input from groups such as employers and non regulated health professionals. The core scopes were all laid down at that time and only a few new ones have been developed since.

Now some 10 years later, the sector will be more aware of any actual concerns or limitations resulting from scopes of practice (as opposed to individual practitioner’s interpretation, which is not reinforced by the RA or the scope).

If during this review there is evidence of widespread restrictive practice, then the RAs should be required to address this and there is a mechanism to do this under Section 127.
HWNZ also needs to assess whether scopes are developed to assist define areas of practise so providers, employers and RAs can assess competence to practise within a scope or whether scopes are to inform the public. The two “audiences” are different and require a different approach and level of detail.

1.5 Improving pastoral care

It is recognised that health practitioners need assistance when going though the RA processes of competence and complaints and that these are stressful for the practitioner. However these processes are coordinated by the RA and it is inappropriate for the RA to offer assistance as the practitioner goes through the processes.

Other events also impact on health practitioners and can be stressful and may lead to health concerns. The RAs' functions include in Section 118 (h); to consider the cases of health practitioners who may be unable to perform the functions required for the practice of the profession.

The result of this consideration may lead to medical assessment, suspension and conditions on or loss of practising certificate. These functions are totally at variance with providing increased pastoral care. A person is not going to seek RA help if they know this may impact on their ability to practise.

Currently many RAs including the Medical Council, do use voluntary agreements so that they can assist practitioners who are ill or unfit to practise without using the disciplinary aspects of the HPCA Act in an effort to increase reporting in this area. That said it is widely accepted that under-reporting does exist because, while the Medical Council and other RAs try to take a rehabilitative approach, they have to operate within statute that is protecting public safety first and caring for the doctor second.

A better solution in this area would be to set up a non statutory group to work with practitioners, providing pastoral care and support or work with groups who already fulfil this role within the sector such as the Colleges. A non statutory group would then only report to the RA when a matter is likely to impact on public safety. Thus separating the roles and functions of legal enforcement and pastoral care.

This type of group operates in several states of the United States, working on a confidential basis to assist the doctors. The principle is that “sick” doctors are more likely to self refer or be referred by peers or family if there is no fear of losing the right to practise. The argument is that this will increase referrals and improve the possibility of rehabilitation so that in turn the public is protected. Such a group would also be able to provide pastoral care to those going through other RA processes i.e. complaints and competence concerns.

Such a group if operated in New Zealand, could assist all groups of health professional covered by the HPCA Act and could also work with other professionals where health may impair practice such as airline pilots, lawyers, accountants and engineers.

Another approach is to set up an arm’s length group such as in the United Kingdom with National Clinical Assessment Service which improves patient safety by helping to resolve concerns about the
professional practice of doctors, dentists and pharmacists in the UK and overseas.

2. Consumer focus

2.1 Public understanding and public involvement

The 2008 review of the Act recommended that responsible authorities and the Ministry of Health do more to inform the public about the Health Practitioners Competence Assurance Act 2003 through their websites, publications and other means, including making business information about registered practitioners freely available.

Some four years later, apart from improved RA websites, there is no great change.

The public need to understand the functions of the RAs when a member of the public has a concern about a health practitioner’s practice and this is often facilitated by the Health and Disability Commissioner and HDC advocates. Transparency of matters such as the complaints process for regulated groups far exceeds the transparency of the processes for non regulated health groups.

However improvements can always be made to public health literacy.

CMC suggests public understanding of the health sector would be enhanced by better title protection and increased clarity in relation to Section 7 of the HPCA Act so that the public are clear on the status and education and training of those treating them.

The paper confuses the role of lay people on the RA board and input by consumers or users of health services.

A lay person is appointed to an RA board to be part of the governance group and therefore needs governance skills. They also represent “public interest” and may balance the views of the professional who may focus on the professions’ interests.

A consumer is someone who uses services (in this case health) and who may be able to give input to the RA development of codes, guidelines and scopes. Thus it would be an advantage in New Zealand to have an external forum made up of people who could give a view on matters proposed by the RAs and many other groups across the health sector.

Several Colleges and the Medical Council already involve the public in their decision making and policy development through consumer forms. This work could be enhanced by such as the development of a community health forum as in Australia so there is an informed group of people (rather than representative groups centred on single health issue) who can ensure public interest is considered by RAs and others in the sector.

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2 In medicine it is considered public understanding would be enhanced by title protection of the term “medical practitioner”, “registrar” and “vocationally registered medical practitioner”. This would required the Medical Council, Ministry of Health and DHBs to work together to inform the meaning of these terms.

3 Community Health Forum of Australia is the peak organisation providing leadership in representing the interests of Australian healthcare consumers working to achieve safe, good quality, timely healthcare for all Australians, supported by the best health information and systems the country can afford.
Lay representation
RAs also have lay persons on their Boards and Councils. It is CMC view that the lay representation on RAs is sufficient (where approximately a third of the members are lay members).

However RA governance could be enhanced by all RA board members being selected on the basis of skills and experience. This matter was to be addressed following the 2008 review but as yet, little has a happened. Work has taken place in the United Kingdom on these matters. Criteria from the UK review and other work in this area is set out in Appendix 1 and could be used in New Zealand.

The purpose of lay person involvement is to represent the public interest and so the most effective lay persons have linkages to their communities.

Public involvement
The “public are already involved in HPCA Act regulation though lay people being on RA boards and their involvement in all committees set up under the HPCA Act which review conduct and practice. This lay involvement on RA boards gives a different perspective to the views of health professions. Competent lay involvement is welcomed by most professional groups regulated under the HPCA Act and this involvement does impact on RA decision making at all levels.

The processes used by the health professions regulated by the HPCA Act are a great deal more transparent than for health professionals not regulated by the HPCA Act.

3. Safety focus
Linkages with other legislation
The sector already does rely on the linkages between the HPCA Act and the Health and Disability Commissioner’s Act 2000, the NZ Public Health and Disability Services Act, and the Health and Disabilities Services (Safety) Act 2001.

These linkages could be enhanced by a common set of definitions of matters for example definitions of phrases such as ‘risk of harm’ and ‘serious harm’ and common approaches to risk assessment.

Using other legislation /standards
The health regulatory sector has not used the New Zealand Standards in development of their work in areas such as standards for risk assessment, consent or cultural competence. This is different to other areas of occupational regulation – for example the Plumbers Drainlayers and Gasfitters Board (which operates in very similar ways and under very similar legislation to the RAs) actively use the NZ Standards in their area as a standard of acceptable practice.

Better linkages of RA work with New Zealand Standards potentially would give a better link between the different RAs work and that of the District Health Boards who are assessed against NZ Standards Health and Disability sector standards. It could also decrease the multitude of different standards and guidelines used across the sector.
Sole practice
In terms of regulation under the HPCA Act sole practitioners have to meet RA requirements. This is a benefit of the HPCA Act and of the individual focus of this type of occupational regulation.

Sole practice of itself is not essentially more risky than for example the risk from an isolated team member working in a large hospital. These risks have to be assessed at the individual level which is why the HPCA Act focus is on the individual.

The Medical Council and Colleges have already developed mechanisms such as peer review, practice reviews and for general practice use of the Cornerstone practice accreditation to mitigate such risks.

4. Cost effectiveness
4.1 Risk assessment
The RAs already operate on an assessment of risk. There is always a balance between decreasing risk and the cost of applying such process. For example risks could be decreased if all practitioners underwent an annual practice review but the cost and disruption to service would be out of proportion to the gains.

Increasingly, RAs are looking at effective methods to identify practitioners that may put the public at risk. This type of risk profiling needs to be based on clear evidence and applied with care.

Defining risk of harm
The working definition developed by the Medical Council has been accepted by the sector.

CMC would not advocate any more detailed definition of harm or serious harm as this may limit flexibility, future proofing and the ability of the RA to intervene.

4.2 Regulatory options
It is understood that one of the key drivers for review of the HPCA Act is that many more groups want to be regulated under the HPCA Act. This desire is not always linked to the risk that the health professional group poses to public safety but HPCA Act coverage is seen to give mana or acceptability to the group. Any increase of the number of groups covered by full statute as by the HPCA Act is potentially costly and unnecessary.

CMC accepts that regulation such as the HPCA Act should be based on the perceived risks for public safety. CMC has no concerns about other forms of regulation if appropriate such as employer regulation and an accreditation system for voluntary registration for groups that pose a lower risk to the public as is now happening in the United Kingdom but any change should be based on robust policy analysis.

CMC endorses the current criteria operated by HWNZ to assess which groups should be regulated by the HPCA Act and which pose a risk of harm (with the inclusion of the words bolded below).

That is, groups that pose a risk of harm to the public includes those that performs:
• Invasive procedures (including but not limited to cutting under the skin or inserting objects into the body),
• Clinical interventions with the potential for physical or mental harm,

**And where the group**

• Make decisions or exercise judgements which can substantially impact on patient health or welfare, where the individuals work autonomously, i.e. unsupervised by other regulated health professional and can set up individual practice.

Some CMC members would include the words bolded above (i.e. **and can set up individual practice**) and consider that, if these criteria were strictly and robustly applied along with the other criteria set out in the Ministry of Health Guidelines Applying for Regulation under the Health Practitioners Competence Assurance Act 2003, some of the current professions would not be regulated by the HPCA Act and most new professions seeking coverage would not reach the bar. This would reduce the growth in the number of regulated group and thus the costs.

However it was also noted by one member that “diagnostic and therapeutic use of ionising radiation such as x-ray and gamma rays should also be included in the above criteria. This may be better tackled by reconsidering the “restrictive activities as set out in Section 9 of the HPCA Act.

Another CMC member supports the need to regulate scopes of practice that include activities that may do harm, **and** are performed by health professionals who may not work autonomously. They note that regulation should be based on a robust scope of practice and for some; this should include the requirement to work under supervision or delegation in order to protect the public while enabling safe, appropriate and flexible practice.

Any change to use other regulatory frameworks (other than the HPCA Act) needs careful policy analysis of the risks, costs and benefits.

One benefit of the HPCA Act is that all regulated health practitioners are regulated in a similar way. The HPCA Act was international ground breaking occupation legislation when introduced in 2003 because the same requirements were applied to all health professionals recognised by the HPCA Act thereby providing a consistent accountability regime for all health professions (Section 3(2) (a)).

One area noted as being useful regulation of all team members under the same frame work is the current situation of the anaesthesia team. For example, before the advent of the HPCA Act - only doctors were protected by the Quality Assurance Activities (QAA) provisions of the Medical Practitioners Act 1995 and this interfered with team review within morbidity and mortality committees as not all team members were protected. Since the advent of the HPCA Act, all regulated health practitioner members of a team have been covered by Sections 52-63.

**Therefore different forms of regulation of different health team members may be counterproductive to improving team work.**
4.3 Data collection
Most RAs do collect data at the time practitioners apply for their practicing certificates. It is accepted that this data is crucial for workforce planning. A change in the HPCA Act under Section 138 to enable the RAs to report non-identified data to HWNZ would overcome most privacy concerns.

That said common definitions need to be applied across all RAs, for example what ‘part time’ is, how many hours are ‘full time’, whether practising means holding practising certificate or actually working. There also needs to be a common data set as for example, some RAs now collect information of practitioners leaving New Zealand - i.e. when the practitioner requests a certificate of good standing.

Extensive work to standardise the data collected was started by the Ministry of Health using the Health Practitioners Index but this work has not been forwarded. This matter should be taken up by the Health IT Board as it will also require linkages with providers and employers data to be effective for workforce planning and cover the large number of non-regulated health worker groups.

4.4 Increasing standardisation across professional groups.
It is noted that the regulatory framework for standardisation across RAs already exists through Section 3(2) (a) where the principal, purpose of the Act is to be implemented by providing, among other things,—for a consistent accountability regime for all health professions.

Standardisation of codes and standards

- The new RAs (i.e. those created since the start of the HPCA Act) did use existing codes of ethical conduct, standards of clinical and cultural competence when developing their own standards, so some synergies already exist.

- This standardisation could be extended through cross RA work and working together to achieve some consistency is explicitly empowered by Section 118(j). (Use could be made of a NZ Standards approach which is used by some other occupational regulatory bodies to get cross sector consistency).

However each group of health practitioners will have their own specific issues that need to be addressed in codes and standards. Some codes and standards link to international instruments and many have a common Trans-Tasman basis therefore one code or standard for all health professionals is not practical or even desirable.

Combined RA secretariats
Some synergies may be possible by combining some of the RA secretariats but this trend must not be at the cost of the basic purpose of the HPCA Act that is to ensure that health practitioners are competent and fit to practise their professions. This requires strong input by the practitioner groups themselves.

Changes in secretariat size should only be made where the benefits can be transparently demonstrated.
Statistic collection so workloads and efficiency can be assessed

The 2008/9 review noted that the work of the RAs may be better assessed if there were some common statistics collected across the RAs i.e. That the Ministry of Health arrange for a set of indicators to be developed, in consultation with responsible authorities and other interested stakeholders, to measure the effectiveness of the Health Practitioners Competence Assurance Act 2003 and to measure the performance of responsible authorities. Work in this area would be of benefit to all, as would the agreement across the RAs to collect a common set of statistics as currently they do not collect the same information in the same way. For example there is no common collection of matters such as the average time to deal with a complaint or the main causes of complaints. More work in this area could lead to cross-RA learning and development of best practice and benchmarking.

4.5 Size and number of RA Boards

There is extensive research on effective size of governance boards, the RA board should be no different and have 8-10 members appointed for their skills rather than groups they may represent. Boards also need to be clear on their role and be selected to bring the required governance skills - see Appendix 1.

It is noted that in the United Kingdom there are fewer regulatory Boards as several of the smaller professions are regulated by the Health Professionals Council. This structure may assist the smaller professions in New Zealand where six of the RAs regulate fewer that 1000 practitioners.

Changes in the number of RA boards should only be made where the benefits can be transparently demonstrated.

4.6 Improving employers’ ability to manage costs

RAs should be mindful of the impact and cost their work has on the sector, that said they are required to implement the HPCA Act. They should work within the parameters of good regulation as developed by the United Kingdom Taskforce on Better regulation i.e. being proportionate in their actions, accountable and transparent4.

It is noted that the DHBs/employers carry the cost of the practising certificates and recertification because of industrial agreements negotiated by the DHBs rather than any requirements of the HPCA Act. RAs are also required to consult on the fees they charge and standards they set.

RAs should consider costs impacts in term of their decisions as long as this does not increase risks to the public.

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4 Proportionate: Regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised.
Accountable: Regulators must be able to justify decisions, and be subject to public scrutiny.
Consistent: Government rules and standards must be joined up and implemented fairly.
Transparent: Regulators should be open, and keep regulations simple and user friendly.
Targeted: Regulation should be focused on the problem, and minimize side effects. (Better Regulation Taskforce, 2007)
RA role creep
RAs should also be required to only take on the roles specifically empowered by the HPCA Act i.e. Section 118 or else there is role creep which can be costly.

4.7 Other issues

Mandatory reporting
CMC members have noted that the current HPCA Act does not require mandatory reporting of possible competence concerns. This type of reporting has been introduced though recent changes in health occupational regulation Australia. Given the complexity of the issue, we suggest that it could be time to have another discussion on this matter in New Zealand.

To forward this matter, extensive consultation is needed with the sector and with other groups such as the RAs and the Health Commissioner.
Appendix 1

The review of health regulation in the United Kingdom in 2007 faced concerns about the functioning of RA boards and consequently developed 12 key principles for an effective regulatory governance board and personal attributes and competencies for Board members including lay people.

Key principles for an effective Board

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<tr>
<td>1.</td>
<td>The board should determine the purpose and values of the RA and review these regularly.</td>
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<td>2.</td>
<td>It should be forward and outward looking, focussing on the future, assessing the environment, engaging with the outside world, and setting strategy.</td>
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<td>3.</td>
<td>It should determine the desired outputs and outcomes of the RA in support of its purpose and values.</td>
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<td>4.</td>
<td>For each of its desired outputs and outcomes, the board should decide the level of detail to which it wishes to set the organisational policy.</td>
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<td>5.</td>
<td>Any greater level of detail of policy formulation should be a matter for the determination of the chief executive/registrar and staff.</td>
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<td>6.</td>
<td>The means by which the outputs and outcomes of the organisation are achieved should be a matter for the chief executive/registrar and staff.</td>
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<td>7.</td>
<td>As general principle, the board should not distract itself with the operational matters.</td>
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<td>8.</td>
<td>The chief executive/registrar should be accountable to the board for the achievement of the RA’s outputs and outcomes.</td>
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<td>9.</td>
<td>In assessing the extent to which the outputs and outcomes have been achieved, the board must have pre-determined performance criteria (KPIs) which are known to the chief executive/registrar and staff.</td>
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<td>10.</td>
<td>The board should engage with its stakeholders regularly and be confident that it understands its stakeholders’ views and priorities.</td>
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<td>11.</td>
<td>The membership of the board should be capable and skilled to represent the interests of the stakeholders; this should not be done in a tokenistic way.</td>
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<td>12.</td>
<td>The board must govern itself well, with clear role descriptions for itself, its chair, and its members, with agreed methods of working and self-discipline to ensure that time is used efficiently and to regularly monitor its performance.</td>
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Personal attributes for RA board members

- Honesty and accountability: Truthfulness and trustworthiness, without compromise of moral principle, and willingness to act on and remain accountable for Board decisions. Accepts own accountability while holding others to account for their performance.
- Commitment: The energy, motivation, time and contribution necessary to properly meet the Board’s requirements and discharge its responsibilities.
- Independence: The strength of character and independence to probe and achieve full understanding of the issues.
- Objectivity: The ability to be objective and free from influence any relationship that could materially interfere with the exercise of objective judgement.
- Leadership: The ability to take leadership roles and to encourage members of the board and management to develop leadership roles and skills.
- Motivation: Motivation and an ability to learn.
- Informed judgement: The ability and intelligence to make fair and reasonable decisions and recommendations in a timely manner based on reasonable assumptions and factual information.
- Integrity: High ethical standards and integrity in all personal and professional dealings.
- Common sense: Sound practical sense in everyday matters.
- Communication: The ability to articulate opinions, rationales and points clearly, logically and concisely, and participate in RA discussions with courtesy and respect. Respects the views of others and is not resistant to change.
- Adaptability: The ability to adopt a flexible approach in team interaction and to alter stances when appropriate.
- Listening: The ability to listen impartially and not be selective, and recall and take into account key points.
- Teamwork: The ability to work harmoniously within a group, to recognise, respect and value the contributions of other members in a diplomatic manner, and to support and accept majority RA board decisions.
Knowledge, qualifications and experience for RA board members

- Experience: Experience and knowledge about the health sector and the regulatory environment.
- Board responsibilities: An understanding of the New Zealand regulatory, legal, fiduciary and ethical requirements affecting members and stakeholders.
- Management practices: Familiarity with up to date management techniques and related ethics.
- Environment: Awareness of health sector environment and impact of professional both nationally and internationally.
- Organisational structure: An understanding of the roles, processes and relationships between the RA and its stakeholders.
- Performance appraisal: An understanding of the key performance indicators of the RA’s Chair and members and the RA’s CEO and/or Registrar.
- Legal and financial: An understanding of legal and financial reporting standards and of accounting principles and practice and information technology: An understanding of the need for and the systems used by RA’s for collecting data on professionals and the ways this can be stored and retrieved and the privacy issues around transferring information.

General Competencies for RA board members

Governance

- Governance: Understanding of governance practices and the ability to distinguish between issues and actions of governance as distinct from management, and not directly be involved in management matters.
- Managing performance: The ability to interpret information and data and apply it to managing and monitoring the performance of the RA and the ability to motivate the performance of the regulator to improve.
- Conflicts of interest: The acumen to identify and declare conflicts of interest on any issue coming before the board.
- Collective responsibility: The understanding of board operation, joint decision making and collective responsibility.

Regulatory and public service

- Public interest/involvement focus: Understands the six Nolan principles of public life
- Public protection: Commitment to protecting patients and to securing public/patient involvement.
- Regulation: An understanding of the health regulation and the context in which it performs the full range of its statutory duties and responsibilities.

5 The Nolan Committee on Standards in Public Life and developed the “seven principles” which are; Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership
### Strategic competencies
- Strategic issues: Including strategic thinking, business knowledge and sound judgement.
- Intra-Organisational awareness: The ability to see the overall strengths and weaknesses of the RA the manner in which it operates and the impact of decisions on the RA.
- Extra-Organisational awareness: An understanding of the position of the RA in relation to the wider health sector, the profession, the media and the public.
- Compatibility and prioritisation: The ability to ensure that strategies, budgets and business plans are compatible with the RAs principal purpose and functions and, in monitoring performance, to identify and focus on those issues that are of significance to it.
- Change awareness: The ability to be alert and responsive to the need for change, to encourage new initiatives and to implement new policies, structures and practices. Able to think and plan based on the long view, balancing needs and constraints, risks and opportunities.

### Analytical competencies
- Financial literacy: The ability to interpret financial statements and statistical information such as balance sheets, profit and loss accounts, cash flow statements and key performance indicators and to recognise their significance, quality and timeliness.
- Critical faculty: Independent thought and the ability to probe the facts, challenge assumptions, identify the advantages or drawbacks of proposals, provide counter-arguments and ensure discussions are penetrating and constructive.
- Information oriented: The confidence to ask for and receive information on matters of significance and relevance, enabling informed judgements/assessments to be made.
26 October 2012

Re: Ministry of Health Review of the Health Practitioners Competence Assurance Act 2003

The Dunedin Community Law Centre (DCLC) is a volunteer organisation that has been in operation for 32 years as a free legal advice, education, law reform and information service. Our aims are:

• To provide and promote community based services that address the unmet legal needs of all cultures in the community.
• To provide and promote legal training and education for university students.
• To promote the dissemination of legal knowledge throughout the community.
• To promote legal services and law reform; which will increase access to justice and reflect the Treaty of Waitangi.

The Dunedin Community Law Centre welcomes the opportunity to comment on the Ministry of Health’s Review of the Health Practitioners Competence Assurance Act (HPCA) 2003. We acknowledge the review is guided by four principle focus areas: Future Focus, Consumer Focus, Safety Focus and Cost-Effective Focus. Our submission will primarily address the Future and Consumer Focus area, particularly the latter which is guided by the principle that ‘Operation of the HPCA Act in a way that is accessible and transparent for consumers.’ The review notes internationally there has been a focus on increasing public engagement and strengthening consumer protection, a trend we would support in New Zealand. Our catchment area comprises of both a rural and urban population, and in this submission we primarily focus on issues and challenges affecting our rural clients.

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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: Natalie Smith

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Organisation (if applicable): Dunedin Community Law Centre

Position (if applicable): Law Reform

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

☐ an individual (not on behalf of an organisation)

☒ on behalf of a group or organisation(s)

☐ other (please specify) .................................................................

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

☐ Consumer ☐ Family/whānau
☐ Academic/research ☐ Māori
☐ Pacific ☐ District health board
☐ Education/training ☐ Local government
☐ Provider ☐ Funder

☒ Non-government organisation ☐ Prevention/promotion

Professional association ........................................ Other (please specify):

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

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

☒ Yes

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

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

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

Questions
Future focus

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

Comment:

We agree that the HPCA Act should include procedures which recognise the shift towards greater teamwork as part of an integrated care model and the complexities of this environment for the health practitioner. We endorse the comments in the report that:

“Increasing inter-professional communication and collaboration, particularly in relation to spoken and written communications and handover of care, is vital to improving the quality and efficiency of health and disability services. The HPCA Act focuses on the competence and accountability of individual clinicians in teamwork situations, but a complementary focus across health professions is necessary to address these common sources of error and inefficiency.”

2

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

Comment:

We would support having broad scopes of practice, as discussed in the section on “Scopes of Practice” and “Information Contained in Scopes of Practice” in the consultation document. Our support for this is made within the context of the provision of health and disability services in rural New Zealand. A National Health Committee (NHC) report on rural health challenges identified that the broad scopes of practice would enable better provision of health care services, such as enabling nurses and ambulance staff to act in a wider range of situations.

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4 Rural Health: Challenges of Distance; Opportunities for Innovation, National Health Committee, 2010, p. 17.
The NHC report noted that rural practice “requires broader scopes of practice, while responsibilities are spread among fewer health workers.” 5 In remote rural areas such as Stewart Island and the West Coast, for instance, nurses currently operate back up services with remote assistance from GPs and hospital doctors.6

In tandem with this, however, there needs to be recognition that rural health practitioners require additional support for training and postgraduate education. As the NHC report notes:

“Becoming a nurse practitioner in rural primary care is difficult due to issues around scopes of practice. It is perceived to be easier to be a nurse practitioner in a city because there are greater opportunities for specialisation.”7

Furthermore, if broad scopes of practice are adopted better support systems need to be put in place to support rural health practitioners. Rural GP’s, for example, often operate 24 hours 7 days a week and have a high burn out rate.

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

The Act could regulate and promote the use of technology, where practical and safe, to assist rural health practitioners meet the demands of multi-disciplinary healthcare. The NHC report noted that the cost of travel and locum cover made it difficult for rural GPs to take time away, but suggested that “interactive education” could be developed online to assist with “maintaining clinical competencies.”8 There is also evidence of telemedicine as a potential tool to overcome distance and isolation in rural areas, although this needs to be carefully regulated with appropriate training and support.9

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

Yes, we believe it is important that the RA’s (Regional Authorities) have a mandated role in pastoral care, and again our comments relate to rural practice.

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5 Rural Health: Challenges of Distance; Opportunities for Innovation, National Health Committee, 2010, p. 13
7 Rural Health: Challenges of Distance; Opportunities for Innovation, National Health Committee, 2010, p. 98.
8 Rural Health: Challenges of Distance; Opportunities for Innovation, National Health Committee, 2010, p. 98
9 Rural Health: Challenges of Distance; Opportunities for Innovation, National Health Committee, 2010, p. 50.
Rural GP’s have highlighted problems which include the lack of locum relief for holidays; lack of access to continuing professional education (this can be alleviated by technology to a certain degree); too much on-call work (this can perhaps be alleviated to a certain degree by broadening scopes of practice) and also a shortage or rural doctors. In addition to this rural healthcare services attract fewer women and Maori GPs.\(^{10}\)

The consultation document’s suggestion of RA’s “‘walking alongside’ health practitioners, supporting them through times of stress ...” is a good one.\(^{11}\) Here again, technology may be appropriate in some cases to support rural practice.

**Consumer focus**

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

From a legislative perspective the HPCA does keep the public safe; however, very few consumers are aware of its existence. There could be more publicity and education around the HPCA Act and its provisions.

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?**

Information from RAs could be more accessible from a consumer perspective.

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

The Australian model of having community representatives rather than lay people would seem more appropriate in a New Zealand context. We would like to see more representation from Maori and Pacific Island communities and rural communities rather than lay people.

This would dovetail with the HPCA’s mandate that one of the functions of RA’s (Regional Authorities) is cultural competence, Section 118 (i) of the Act:

\[(i)\text{ to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession}.\]^{12}\n
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\(^{12}\) Health Practitioners Competence Assurance Act 2003, p. 95.
10. Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?

Consumer forums can work well in some instances, but they need to be tailored to meet the differing needs of the consumer and the community. Both bring different perspectives to health care. A recent study has drawn attention to the distinction between “community” and “consumer” where consumer issues were identified with specific things that related to an individual such as waiting times, and the quality of the premises in which health care is delivered. Community issues were issues that affected the community.\textsuperscript{13} These could be things such as the quality of housing.

We are unsure if the HPCA is the right mechanism through which to address consumer issues. The HPCA currently interfaces with the Health and Disability Commissioners Act 1994 which promotes the rights of consumers using health and disability services.

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

Comment:

The primary focus of our submission is rural health, the challenges faced in the delivery of rural health and disability services, and the flexibility required in the HPCA to safely deliver services that meet the needs of folk in rural areas. Increasing use of technology is one way to offer support to the rural GP, but for this to happen there needs to be greater collaboration with government agencies to improve facilities like high speed internet access. This would allow telemedicine, for example, to be used safely, more widely and less erratically. There could also be an improvement in cell phone coverage. In concluding we would like to draw attention to a comment made in the NHC study:

“The NHC found that to meet the health needs of rural communities more emphasis is needed on comprehensive primary health care, the use of supportive technology (medical and nonmedical), and visiting services and transport support. Supportive business models, community governance, broader scopes of practice, and contracts and funding arrangements that are flexible, sustainable and efficient will enable better and more appropriate service delivery.” \textsuperscript{14}

\textsuperscript{13} Pat M. Neuwelt, “Community Participation in Primary Care: What Does it Mean ‘in practice’?, Journal of Primary Health Care, vol. 4, no. 1, March 2012, p. 34.

\textsuperscript{14} Rural Health: Challenges of Distance; Opportunities for Innovation, National Health Committee, 2010, p. 7.
Thank you for the opportunity to comment on this document.

Yours sincerely
Natalie Smith
Law Reform
Dunedin Community Law Centre
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

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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)
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☐ other (please specify) ...........................................................................................................................

Please indicate which sector(s) your submission represents
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☐ Professional association

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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:

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 minimising statutory regulation and state registration.

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 discouraging "responsible authorities" from extending what are essentially clinical scopes of practice into the field of education (as have the Dental Council, the Medical Council, the Occupational Therapy Board, the Optometrists and Dispensing Opticians’ Board, the Physiotherapists’ Board, the Podiatrists’ Board, the Psychologists’ Board, and the Psychotherapists’ Board).

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 different health professions currently covered by the HPCA Act have different histories, and different philosophical foundations; it would be both impossible and undesirable to “standardise” their respective codes of conduct, ethics and (un)common learning.

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

This is in part due to the fact that:
1. The HPCA Act cannot keep the public absolutely safe.
2. Public safety is more likely to be ensured through education not regulation.
3. In some fields, e.g. psychotherapy, there is no evidence that the state registration of psychotherapists protects the public. (There are now 11 books on this subject in the field of psychotherapy alone, and not one which provides any research-based evidence in favour of statutory regulation.)
4. That Act does not keep the Māori public safe as there is no reference to Te Tiriti o Waitangi (see final comments and separate submission from Nga Ao e Rua)

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:

One problem with most RAs (and they are Councils as well as Boards) is that they are for the most part unelected and, therefore, not only unrepresentative of the profession, they are also, in effect, political appointments. Also, some “laypeople” are, in effect, professional regulators. This was the case with the first composition of the Psychotherapists’ 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:
This is a biased question. The policy of statutory regulation is only one way to ensure or, more accurately, to promote public safety; and, as Appendix 4 of the Discussion Document acknowledges, there are a number of models of occupational regulation (and there are more than the ones noted).

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:

Absolutely. The Code of Health and Disability Services Consumers’ Rights (Health & Disability Commission, 1996) is perfectly adequate to manage the protection of the public; and well-established professional associations are adequate to regulate health practitioners.

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:

Any revision of the HPCA Act needs to acknowledge Te Tiriti o Waitangi is missing (see final comments). At the time the then Health Practitioners Competence Assurance Bill was in progress through Parliament, this omission of Te Tiriti | the Treaty was justified by the Ministry of Health (2003) in a three page statement in which it simply 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 Māori 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)

This is patently not the case: the RAs by and large have a poor record in engaging with Māori health practitioners and observing either the letter or the spirit of Te Tiriti | The Treaty. In the case of the Psychotherapy Board, it has consistently refused to engage with Waka Oranga, the national Māori roopu of psychotherapists.
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:

Most of the MoH’s discussion of and policy changes regarding risk lies outside the HPCA Act.

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

Comment:

I would suggest that this is field specific and that the Ministry should approach the relevant professional associations which have been thinking about and developing policies and procedures about risk management for many years longer than have the RAs.

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 question is not clear.
Cost effectiveness focus

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

Comment:

In my experience and reading of the activities of the Psychotherapists' Board, very little.

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

☐ Yes
☒ No
☐ Not sure

Comment:

Again, as this is field specific, it is hard to see how any one definition would be useful.

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:

As above (Q18).
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:

Absolutely not. The Act is not sensitive enough to do this. (This is partly due to its provenance from the Medical Practitioners Act 1995). Any person who or government that is broadly in favour of de-regulation needs to devolve this question and the issue/question of harm to the relevant professional associations.

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

☒ Yes
☐ No
☐ Not sure

Comment:

1. By being more trusting of the profession they regulate.
2. By seeking to educate the public rather than regulate the profession.
3. By adopting a “lighter touch” to their activities.
4. By withdrawing all scopes of practice other than the clinical. (Some RAs are seeking to extend their powers and influences into all sorts of activities, such as education and training, research, policy-making, etc., again with no evidence).

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

☒ 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, by deregulating psychology and psychotherapy (as there is no evidence that this protects the public), and possibly by combining some of the RAs that are closer to each other by virtue of sharing the medical model of and approach to “health”.

24. What is the ideal size of RA boards?

Comment:

25. Are there other issues you would like to raise? Yes (see below).

I am concerned about a number of features of the Act and this consultation:

Regarding the Act

1. Its provenance is entirely medical and it does not account for historical or contemporary discussions about health; and it encompasses at least two professions – psychology and psychotherapy – that, for the most part, hold different views of health and illness than do most “health” (medical) practitioners.

As the MoH (2010) stated on its website about the Act: “The HPCAA builds on the framework created by earlier legislation, in particular the Medical Practitioners Act 1995. All the major concepts of the Medical Practitioners Act 1995 have been carried forward into the HPCAA”. It claims these principles have been “adjusted where necessary to generic terms to provide a framework that can apply to all health practitioners and not just doctors.” However, reading the Act, it is apparent that this adjustment was a token one: the word “medical” still appears 136 times in the HPCA Act – and the word “therapeutic” is not mentioned once! Moreover, reading the Medical Practitioners Act 1995 alongside the Health Practitioners Competence Assurance Act 2003, it is clear that they bear an uncanny resemblance.

2. The Act aims to protect the public by restricting professional titles (see §§5, 7, and 27); by prohibiting practitioners from practice and certain activities (see §§8 and 9); and by punishing practitioners who are incompetent, unfit to practice, or unable to perform their required functions by means of suspension (§§39, 43(1)(b), and 48); the prescription to complete a competence programme (§40) or a recertification programme (§41); and
variation of their scope of practice (§43(1)(a)). As a piece of legislation it is based on a
deficit model in that it does not define competence, fitness to practice or, for that matter,
good practice except insofar as it legislates about incompetence or failure to meet “the
required standards of competence” (§38), the “inability to perform required functions”
(§48), and the (seven) factors that warrant discipline (§100), about which the decisions of
the Health Practitioners Disciplinary Tribunal (see http://www.hpdt.org.nz/) and case law
provide interpretations. Despite the title of the Act, there is very little about assuring
competence. The initial Sections of Part 3 of the Act, “Competence, fitness to practice,
and quality assurance”, are all framed in terms of health practitioners who pose a risk of
harm to the public.

3. While the Act is largely based on the certification of title as distinct from the licensing of
activity, most RAs have sought to regulate the activity of the profession and, indeed,
other, related activities.

4. The original Act made no reference to Te Tiriti o Waitangi | The Treaty of Waitangi (see
separate submission from Nga Ao e Rua).

5. The Act contains some powers which are somewhat worrying from a human rights
perspective, e.g. Section 10(1):
in respect of an offence which has been or is suspected to have been committed
against section 7 [claim to be a health practitioner] or section 9 [activities restricted to
particular health practitioners] or which is believed to be intended to be committed
against either section, even though the offence is not punishable by imprisonment
(our emphasis). (§10(1))
The idea – and reality – that authorities have the power to search a person’s premises
because someone (presumably on an RA) believes that a person intends to commit an
offence under sections of the Act is Orwellian – and, in the case of the Psychotherapists’
Board is a particularly bizarre view for a psychotherapist to take.

Regarding the Review
6. 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
due to be the subject of this next, and further 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 – and, yet, in the MoH’s discussion document,
• There is no reference to this being a review of underlying policy settings;
• There is no reference to the previous submissions which referred to the Te Tiriti;
• There is no reference to Te Tiriti; and
• There is no justification of the four principles by which the HPCA Act will be assessed,
or of the (limited) scope of the review.

7. Given the nature of the Act, the review, the discussion document and the delay in the
publication of this document, the Ministry has allowed comparatively little time for
submissions.
26th October 2012

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

Review of the Health Practitioners Competence Assurance Act

On behalf of the 20 District Health Boards Directors of Nursing, thank you for the opportunity to comment on the review of the Health Practitioners Competence Assurance Act (HPCA, 2003).

The feedback indicates:

- There is general support for the intent and application of the Act. Working with other statutes e.g. Privacy Act and Health & Disability Act, it enables a regulatory framework which provides public protection.
- Since the introduction of the Act, there has been an increase in understanding of the scopes of practice, direction and delegation and the professional obligation to maintain currency and awareness of the competencies.
- It is believed the competency framework has increased the likelihood of public safety, in particular the mandatory reporting requirements.
- The current consultation paper does not identify any particular problems with the current Act which would require substantive change.

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 already allows for flexibility, as an example; the Nursing Council has already proved responsive to a changing workforce with the expanded practice role. Boundaries need to be made clear as new workforce innovation occurs; nursing scopes are broad and often overlap with other professions.
2. How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?
   - The introduction of new types of health worker and the unregulated workforces are identified as issues for the Act and future framing.
   - Ensure that the wording in section 11 does not lead a regulatory authority (RA) to describe a scope of practice in too prescriptive a manner; this could limit the development of a more flexible 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?
   - The RA role is to ensure educational providers are adhering to standards, and to take action if this is not occurring.
   - The profession, employers and educators work together to ensure education is appropriate for the workforce.
   - Nursing competencies already focus on these areas.

4. Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?
   - No. We do not support a standardised code for all professions; codes provide detail in the standards of conduct expected of a particular profession rather than a set of broad principles. This is useful for the practitioners and members of the public.

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. We support broad scopes of practice; (see ques 1) they are necessary for the provision of consumer focused care. The profession, the practitioner and the RA can inform consumers on what to expect from a health practitioner, taking into account the principles in the Code of Health and Disability Consumers’ Rights.

6. Could RAs have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?
   - No. RAs are required to follow the processes laid out in the Act. It would blur the boundaries and risk impartiality should the RA be required to provide pastoral care services. This is the role of the professional associations, unions, employers and other representatives/support people. The Health Committee and Competence Review processes already have a remedial intent by the use of orders and conditions on practice, balanced with public safety.
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, the HPCAA does give a high degree of public assurance for safety. Complaints mechanisms, particularly with the HDC are well known.
   - It is our view that the Nursing Council supports consumer involvement, some of which is already mandated under the Act. The Nursing Council has lay people on their delegated committees.

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?
   - There needs to be a balance between the Act and transparency. There is also the Privacy Act to consider. The RAs should ensure the actual complaints process is publicly available, and online registers should note any findings.
   - Fair process and natural justice should be observed until a finding is made. The issue of prurient interest is a reality. If an employer is involved in other employment disputes with the nurse, revealing information from a disciplinary or competence process could be detrimental for the nurse.

9. Do we have the right balance of laypeople to health professionals on RA boards?
   - Yes, to the right balance. The Nursing Council current structure is 6 nurses and 3 lay people.
   - Nursing is seen in every area of health, so it is vital not to reduce the breadth of understanding of the health sector and of the broad nursing contribution to health.
   - The role of the layperson is important for maintenance of public safety and to represent the consumer. Important the laypeople are appropriately trained.
   - There is a difference between lay and consumer representation and it would be helpful if the Act made this clear.
   - No to appointment processes: There are lay representatives on RA boards who are political appointments. Freedom from political influence should be assured by the Act. This is not the case at present and is of concern.

10. Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?
   - No, to consumer forums, another expense for RAs. Even if this was to be considered, a full trial to assess the usefulness of such a mechanism in improving the public safety would be required before any changes to the Act could be considered.
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, we believe current use of the legislation is keeping the public safe and that this Act, along with other Acts, protects public safety.

12. Can we make better use of other legislation or employer-based risk management systems and reduce reliance on statutory regulation?
   - Nursing Council often acknowledges the role of employer organisations. District Health Boards as employers have significant systems in place which already address risk and safety.
   - Many other employers, particularly small organisations, often with non-health owners or managers may not have performance management systems in place, or be able to adhere to performance management timeframes or goals setting.
   - Any employer based system would need to be consistently applied, and have the personnel and knowledge to apply it. This would be an employer responsibility.
   - RAs must not be seen to be deterring employers from appropriately notifying, but could provide advice or links to performance management systems. If there was a preferred system across the sector that would be easier to manage and train with, maybe utilise Learnonline.

13. What more needs to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?
   - As stated previously, we don’t see significant gaps in the legislation.

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; the HPCA Act is clear about the level of risk that needs to be regulated by statute.
   - Different levels of regulation may cause confusion.

15. Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?
   - The individual practitioner, regulator, employers and professional organisations all have a role to play in managing risk. The regulator and employer can ensure that each practitioner is managing their risk by ensuring they are maintaining competence and providing evidence of peer review of their practice.
   - It would be useful to strengthen wording in the Act around the need for health practitioners to engage with their professional networks.
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?
   - There is a broad spectrum of professions and those regulated under the Act are accountable as they must comply with the Act, for those that are non-regulated, there is no accountability to the Act, this is where risks arise. The Act does provide huge value here.
   - In delegation to the non-regulated workforce, Nursing Council has robust Direction and Delegation guidelines, which has significantly raised awareness of the accountability of registered and enrolled nurses.

Cost effectiveness focus
17. What role do RAs play in considering the cost impacts of their decisions and the cost benefits of regulation?
   - RAs are fully funded by the practising certificate fee as well as charging for approval/auditing of education programmes. We believe Nursing Council works in an extremely cost effective way.

18. Should the HPCA Act define harm or serious harm?
   - We note that RAs have developed a standard framework for risk of harm and serious risk of harm.

19. Is HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?
   - The Nursing Council has engaged with employers on what is appropriate for the RA, employer, nurse and professional organisation to manage. We believe the Nursing Council has achieved a balance between managing the risk to the public, professional accountability, and non-statutory regulation.
   - The RA provides the guidelines. Implementation and decision making is done by the practitioners and employers using a variety of frameworks e.g. The expanded practice framework for nurses.

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; though we can only comment knowledgeably on whether or not the regulation suits the nursing profession.
21. Could the way RAs administer their functions be improved?
   - Yes; always, as with any organisation. It is more important that RAs are consistently striving to improve.
   - The Nursing Council has already made significant improvements over the last 2-3 years. For example: It has introduced on-line annual practicing certificate renewal and on line registration for New Zealand graduates.
   - RAs could improve communication, to ensure all practitioners and employers understand clearly the role of the RA.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   - The Nursing Council already consults broadly, however the language used has often been difficult to interpret, we see the role of the RAs as interpreters or translators of the Act.

23. Should the number of regulatory boards be reduced, as in the UK?
   - We strongly object to a single RA.
   - Rather than a reduction, the RAs who oversee very small numbers of practitioners could align with others who are significantly similar, maybe complimentary clusters for shared learning and resources.
   - There could be some benefit in a shared data collection system to enable more detailed analysis of the regulated workforces.

24. What is the ideal size of RA boards?
   - Between 8 and 12 is probably fine, need to balance experience and cost effectiveness.

25. Are there other issues you would like to raise?
   - If a practitioner is under orders they can re-take previously failed courses without limit, as well as switching course providers. It would be useful if the HPCA could have a limit on the number of times a practitioner can re-take education courses under orders.
   - Under section 38(1) the RA should be able to suspend the registration of a practitioner if they do not participate in the review process, or if they have already been the subject of a previous review and have failed to maintain competence standards after previous orders ceased to have effect.
   - Nursing leaders have easy access to a responsive RA with professional expertise and this is important to maintain.
   - Strengthen the wording in the Act, section 37(2) around practitioners accessing appropriate support people when referred to the RA for practice issues.
   - Enable the RAs to apply psychological evaluation as part of the assessment requirements for those practitioners referred for competence who show; lack of insight, cognitive functioning problems, and behaviour or attitude issues. You
can deliver care that is clinically competent but uncaring. Attitude and character are as important as competence.

General comments:
• The consultation paper and questions were not directly related to the structure of the Act; consequently it was difficult to respond directly to the questions.

Please do not hesitate to contact me if you require any further information. sue.wood@midcentraldhb.govt.nz or by phone on (06) 350 9140

Yours sincerely

[Signed]

Sue Wood
Vice- Chair

For the 20 District Health Boards
Lead Directors of Nursing

Cc: Dr Jane O’Malley, Chief Nurse, Ministry of Health
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.

<table>
<thead>
<tr>
<th>This submission was completed by:</th>
<th>Alison Paulin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address: (street/box number)</td>
<td>Level 11, Support Building, ACH, Private Bag 92 024</td>
</tr>
<tr>
<td>(town/city)</td>
<td>Auckland</td>
</tr>
<tr>
<td>Email:</td>
<td><a href="mailto:alisonp@adhb.govt.nz">alisonp@adhb.govt.nz</a></td>
</tr>
<tr>
<td>Organisation (if applicable)</td>
<td>Auckland District Health Board</td>
</tr>
<tr>
<td>Position (if applicable):</td>
<td>Professional Leader, Speech Language Therapy</td>
</tr>
</tbody>
</table>

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): Speech Language Therapists at Auckland District Health Board

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
- [x] 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
- [x] 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:

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?
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?

☑ No
☐ Not sure

Comment:

From what I know of RAs, this is not their role.

The HPCA Act does not currently keep the public safe from Speech Language Therapists who are not qualified, are abusing their position or are not competent to practise. This is because Speech Language Therapists are not subject to compulsory regulation under the Act.

We believe SLTs should come under the HPCA Act to provide protection for vulnerable clients (who often include people who have difficulties with verbal and written communication, meaning complaining or advocating for themselves is very difficult) from Speech Language Therapists (SLTs) who pose a risk to clients.

SLTs work with people across the lifespan who have swallowing difficulties, independently evaluating and making recommendations about whether to feed a person orally or not. They replace speaking valves in the trachea of people who have laryngectomies. They place temporary endoscopy tubes into people’s laryngeal vestibules via the nose to assess swallowing (FEES) and lead videofluoroscopic evaluations of swallowing within radiology suites. Errors in clinical decision making in these areas can result in adverse outcomes for clients, including pneumonia and death. SLTs who are not qualified, abuse the power inherent in their positions, or are not competent to practise in the areas they are practising in pose a significant risk to clients and there is currently no system in place for reporting these people.

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

Comment:
I have had no direct involvement in any RA so am not able to answer many of these questions.

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
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 have an obligation to ensure SLTs are competent to practise in the clinical area they are employed in. Auckland District Health Board takes this responsibility very seriously. My role is one of several put in place to ensure standards are met, and to ensure sufficient support is provided for staff to carry out their roles. However many SLTs working in private practice work in total isolation and there is no compulsory requirement for those SLTs to undertake supervision, ongoing training or review of competency. This may put clients at risk.

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:

We believe that Speech Language Therapists should be subject to compulsory regulation under the HPCA Act (see above).

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
2012 Review of the Health Practitioners Competence Assurance Act 2003

No
☑️ Not sure

Comment:

If the Ministry of Health believes that regulation is not an option for SLTs due to perceived low levels of risk or high costs, it would be better for all parties if this was communicated to the profession as soon as possible. Waiting for years to hear about the outcome has been extremely frustrating for members of the profession and has delayed progress in putting in place increased protection through the New Zealand Speech Language Therapists’ Association (NZSTA).

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

Comment:

☑️ Supervision and independent annual peer review.
☐ Regular random client audit (face to face from a skilled person to gain feedback from clients with communication disorders).

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 acknowledge the profession of Speech Language Therapy (SLT) is small and that this means the costs of regulation are higher per worker. To mitigate this, we propose that SLTs could be regulated under a Board that is already in existence, such as the Psychology, Dietetics, Audiology or Occupational Therapy Boards. An alternative is to regulate the profession of Speech Language Therapy in the same way that Teachers are regulated in New Zealand. The majority of SLTs in NZ work for the Ministry of Education.

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:
   See answer to 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
Comment:

It is all or nothing at present. (cf Australian model). While as a group Speech Language Therapists believe in the importance of compulsory regulation for our profession, if this is not going to occur, a strengthened self-regulation would be preferable to the vacuum we currently find ourselves in.

21. Could the way RAs administer their functions be improved?
   - [ ] Yes
   - [ ] No
   - [x] Not sure

Comment:

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

Comment:

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

Comment:
We are supportive of exploring any options that may have the potential to reduce costs and get the Speech Language Therapy profession regulated (as in the UK).

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

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

We believe that our profession is seen as 'low risk' for two reasons:
  a) low numbers of client complaints. In fact we see this as concerning as our clients often do not have the communication skills to complain about inappropriate care.
  b) physical harm to clients attributable solely to SLT care is rare. In fact multidisciplinary teams in healthcare contexts rely on SLT assessment and advice to manage swallowing disorders and errors in judgement do result in pneumonia and death.
How to have your say

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

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

This submission was completed by:  (name) Hayden Thomas

Address:  (street/box number)  10 Church Street
(town/city)  Nelson

Email:  hayden@chiropractic.org.nz

Organisation (if applicable):  New Zealand Chiropractors’ Association

Position (if applicable):  2nd Vice President

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
- Family/whānau
- Māori
- District health board
- Local government
- Funder
- Prevention/promotion

- ✓ Professional Association
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Do you wish to receive a copy of the summary of submissions?
- ✓ Yes
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 agree that a more integrated care approach is best for patient outcomes.

In the past the chiropractic profession has not been as integrated as it could/should be due to historical biases and misconceptions from within the dominant allopathic model and some of these still persist today. This is also true for a number of the other allied health professions and complementary or alternative approaches to health care.

We note that while integration is desired, there are potential conflicts with differing philosophies and best practices. Integrated care requires a shift at the managerial and practitioner level driven by MOH funding models and ACC. The current issue of dis-jointed care is larger than the HPCA Act can solve but it could support it.

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 to the HPCA Act should not be a reactionary piece of legislation to try to fix problems of the health care system that could be better dealt with by looking to the causes. Many of the challenges faced by the current system may be better addressed with a paradigm shift from sick-care to health-care with prevention and a proactive approach towards causes of issues especially obesity, diabetes, and
neuro-musculo-skeletal deconditioning due to modern lifestyle. These top burdens on the health system come from preventable lifestyle related choices and the sheer weight of these issues is encumbering the system. We need to look at a more sustainable model of health care not legislative “fixes” to increase the number of health care professionals and services that are currently the mainstay of our system.

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:
   This is perhaps beyond the scope of the Act and more the domain of the training institutions and professional associations. Enhanced professional communication, courtesy and integration could be assisted by specific ethics and codes of conduct.

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 Act could promote a basic standard for all primary contact providers (with a simple version for the public) while recognising that RA’s will have more specific codes relevant to their unique profession.

   Standardisation of the formats of the current Code of Ethics and Standards of Practice already existing for each profession would be useful for both health professionals and consumers to more easily understand and compare.

   A centralised site for making this information on the various professions and scopes would be useful.

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
We feel the current chiropractic scope is sufficiently broad but shows our distinct contribution to the health care landscape. However, the question needs to be asked what is the true purpose of a 'scope of practise'? Then an assessment can be made of its current usefulness from a professional and public perspective.

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:

Preferably the RA’s would have a collegial, supportive approach to competence issues with strict disciplinary/corrective measures reserved for significant or repeat digression from acceptable standards. We are unsure how a mandated role in pastoral care would be implemented or funded. Would it be a general supportive/counselling service to all practitioners and/or profession specific?

**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:

Anything that can help keep up standards will assist public safety.

One issue regarding the Act and safety arises around those people that are not part of a regulated profession or have been de-registered but still practice elements or the full scope of a registered practitioner. These practitioners don’t
fall under the HPCA Act unless they are performing a restricted act - which they may be doing unknowingly or knowingly but can only be pulled up if there is a complaint made to the regulatory board. In our profession we have had a number of instances of this and the board is powerless unless complaints are lodged. Part of the problem arises from the public not knowing about the value of, or how to choose, a registered health professional or what acts are restricted and who can perform them.

Has any assessment been made of public perceptions of the value of health practitioner regulation and discipline?

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:

There could be better visibility and promotion through the HDC, HPDT and MOH websites for the public to understand the process and outcomes.

Perhaps all guilty decisions should be mandatorily published by each RA?

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

Most likely yes, although the laypeople serving on the boards are not the average public/consumer. However, we are not sure it is advantageous or even possible to have average citizens serving on the boards?

One suggestion posed under this topic was whether the various boards could be more efficient by using the same laypeople to reduce total number and expense rather than have so many serving under the various RA’s.
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:  
RA’s should be responsible for ensuring that easily available channels for consumer and community feedback are set up and maintained; a separate consumer forum for each RA is probably not necessary or efficient.

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 question whether appropriate disciplinary measures are available for significant misconduct or repeat offenders.

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:
Any legislation or regulation needs to take the sole practitioner or small group practice scenario into account. Chiropractors do not currently work for DHBs or generally even in large employer/employee relationships. Most multi-chiropractor practices are contractor based so employer based systems are not a major influence for 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 there are issues with the Trans-Tasman Mutual Recognition legislation overriding the HPCA Act which means people registering from Australia don’t necessarily meet practice conditions in New Zealand. This creates a problem in that RA’s are unable to insist that these practitioners meet standards relating to cultural safety and NZ public health issues.

Lack of cultural safety, and awareness of appropriate practice styles can cause intra and inter-professional misgivings and issues with consumers leading to complaints.

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 act of applying high-velocity, low-amplitude manipulative techniques to cervical spinal joints especially should be maintained as a restricted act to those professionals specially qualified and extensively trained in its safe delivery.

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

Comment:
A robust Continuing Professional Development programme may assist with risk management and identifying those isolated or sole-practitioners who might have potential issues.

There could be increased direction and support from RAs for the education of practitioners on pertinent risk management topics and provision of easily implemented tools or solutions. Some of this could be interdisciplinary and help form a more informed and collegial workforce.

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:
   Within our profession there is currently tracking of complaints and a CPD programme underway to help highlight and assist people to minimise risk.

   There is the potential for an overly aggressive risk profiling system to create an unproductive environment with a punitive attitude from the RAs and defensiveness among practitioners.

**Cost effectiveness focus**

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

   There needs to be a balance of costs to practitioners through the Annual Practicing Certificate fee and consideration for the Board upholding public safety.

   One issue arises with the cost of complaint resolution and how this can be a significant impact on limited resources with drawn out expensive processes. We suggest the complaints process may be able to be simplified, expedited and better use made of alternative dispute resolution processes.

   RAs need a better ability to seek to recoup full disciplinary costs from guilty parties to assist in cost containment and for fairness to APC holders.

18. Should the HPCA Act define harm or serious harm?
   Yes
   No
Harm and serious harm can usually be assessed in the context of complaints on the particular facts.

The HDC could perhaps look to set those definitions in consultation with the various professions and wider community and RA's be required to reference to those definitions when assessing situations where harm may have occurred.

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 would be helpful to all consumers if both regulated and unregulated health practitioners had to declare their status vis a vis the HPCA Act and the protections the consumer can therefore expect.

   While there are certain regulated or restricted acts under the HPCA Act, they are likely not well known to the public and this poses definite safety issues with unqualified or non-registered practitioners performing them on an unsuspecting 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?
   Yes
   No
   Not sure
   Comment:
   There appears only one current ‘regulatory option’ for health practitioners via the HPCA Act beyond the H&DC Act.

21. Could the way RAs administer their functions be improved?
   ✓ Yes
No
Not sure
Comment:
There needs to be more formal avenues for wider stakeholder input – to assist RAs and hold them accountable.

Efficiencies need to be found for RA’s administering relatively small numbers of professionals due to excessive overhead costs on practitioners.

22. Should RAs be required to consult more broadly with relevant stakeholders?
✓ Yes
No
Not sure
Comment:
RA’s need to more formally identify key stakeholders (such as professional bodies and educational institutions), including those within the broader health sector and amongst consumers, and ensure that relevant feedback on major activities and decisions being made is gathered and considered.

We suggest an improved interface between the profession and RAs than just via the Registrar. Defining good channels of communication will be especially important if there is to be merging of the secretariats and central administration.

23. Should the number of regulatory boards be reduced, as in the UK?
Yes
No
Not sure
Comment:
A merging or reduction of the number of Boards may have financial advantages in cost to practitioners and some benefits to public safety but is not necessarily advantageous for small or distinct professions. Certainly some of the RAs administrative functions and operational overhead could be shared for improved efficiencies.

Disciplinary and Scope matters must still be assessed by a majority of peers.
24. What is the ideal size of RA boards?
Comment:

Proportionate to their issues and registrants.

25. Are there other issues you would like to raise?
Comment:
Submission in response to the Ministry of Health’s


26 October 2012
26 October 2012

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

The Nursing Council ("the Council") welcomes the opportunity to submit on the discussion document and assessment of the Health Practitioners Competence Assurance Act 2003 ("the Act"). As previously submitted, the Council is of the view that the Act is achieving its purpose of protecting the health and safety of the members of the public.

Introduction of the Health Practitioners Competence Assurance Act

The Council notes that the introduction of the Act in 2003 was, in part, a response to the issues that arose during the Gisborne Cervical Screening Inquiry (2000) and the obvious need to provide mechanisms to ensure that all health practitioners are competent and fit to practise their professions. The Council is of the view that, where there are real and significant risks to public safety the need for regulation is of vital importance and that regulation of a health practitioner’s competence, conduct and health must be undertaken by an independent regulatory authority and cannot be left entirely to the individual or his or her employer.

The competence provisions of the Act have enabled the Council to ensure that nurses maintain their competence to practise and, where issues have arisen, to review competence and include conditions to protect public safety.

The Council agrees that consumer protection should be strengthened, as should the requirement for Regulatory Authorities (RAs) engagement with consumer groups to ensure they are fulfilling their purpose. The Council already has consumer engagement as part of its strategic plan up to 2015.

Structure of the Council’s submission

The Council also welcomes the opportunity to submit on the operational functioning of the Act and has attached to this submission a document that sets out its recommendations for legislative amendment that would enable it to better protect public safety, provide pastoral care and reduce the costs of regulation (Attachment one).

Future Focus

Integration of primary care with other parts of the health service

The Council agrees that RAs need to work with the sector to ensure that the scopes of practice and qualifications for each scope are in line with health sector requirements of today
and the future. To this end, the Council has already introduced the Enrolled Nurse scope of practice and provided guidance to nurses and employers on expanded practice roles for Registered Nurses. The Council is currently consulting or about to consult on the following:

- Nurse prescribing and how this could be effected, particularly for nurses in the community
- The nurse practitioner scope of practice, including the process and qualifications for registration in this scope

However, the Council notes that under existing legislation it is not mandated to create the workforce. Its role is limited to ensuring that the nursing workforce is safe.

**Discussion questions**

1. **How can the Act improve the integration of health care and service models?**

   The Act needs to ensure that there is sufficient flexibility to enable RAAs and the healthcare sector to explore new models of care. The Council has already developed the expanded scope of practice under the current Act to enable registered nurses to practise outside the more traditional boundaries of nursing practice. It is of the view that this expanded scope has worked well in providing flexibility and enabling nurses to undertake more technically complex aspects of the practice of nursing while providing the nurse, employer and the public with reassurance that public safety is being protected. This has been well received by employers.

   In the Council’s view the Act in its current form does not impede such expansion and it was able to readily implement that expanded scope following consultation with the health sector.

   The Council is currently consulting on nurse prescribing and is of the view that the Act does not restrict the ability of the Council to develop a scope of practice or authorisation that will permit nurses to prescribe in the future.

   An important function of an RA is to ensure that it communicates fully with the profession and other professions to address any concerns practitioners may have with the blurring of boundaries. This is particularly relevant in nursing practice where there are often overlaps with other scopes of practice.

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

   The Council notes that the current wording of section 11 may lead a RA to describe a scope of practice in a prescriptive manner and is of the view that this limits the development of a more flexible workforce.

   The Council has adopted a very broad scope of practice and has used conditions to limit the areas where some nurses can be employed. It is about to embark on further consultation as to whether or not these conditions should be revised. The Council welcomed the provisions in the Act which permit it to authorise changes to a scope of practice (section 21(2)) and uses this provision extensively to enable
nurses who have attained additional qualifications, education or experience to practise in other areas (e.g. mental health).

The Council notes that the principles for developing and reviewing scopes of practice that were identified in the 2007-2009 review could be incorporated into the Act as a guide to developing scopes of practice rather that the examples of how scope of practices may be described in section 11 (Page 7 of the discussion document).

However the Council disagrees that the principle to guide authorities should read “setting qualifications that are the minimum requirements for public safety” and suggests that this is setting the bar too low.

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

The ability of an Act to promote education that has a wider focus is limited. The Council’s view is that it is up to the profession, the employer the authority and the educational institution to work together to ensure that the agreed education for the scope of practice is providing the skills to practise in an integrated workforce. The role of regulation is to develop the overarching education standards necessary to prepare safe and competent practitioners and ensure that educational institutions are adhering to the standards that are developed out of that collaborative process and to be able to take appropriate action if this is not occurring.

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

The Council notes that although regulated under the same Act there are a great many differences between some of the professions, including the amount of interaction with the health consumers they are providing care for, the power imbalance between those practitioners and the consumers and the degree of exploitation or harm that can occur. For those reasons the Council does not support complete standardisation of codes and is of the view that codes need to be profession specific, although there will be some common themes. The RAs do already consult and comment on each others codes but a standardised code for all professions would not provide as much guidance and direction as a profession specific code does.

The current trend is for codes to provide a lot more detail in the standards of conduct expected of a particular profession rather than a set of broad principles. This has been seen as more useful, not only for the practitioners, but also for members of the public who are encouraged to access these codes. This requirement for clarity may mean that there is a greater need for profession specific codes that have common themes.
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?

The Council notes that broad scopes of practice are necessary for the provision of consumer focused care and is of the view that it is up to the profession and the authority to inform consumers on what they can expect from a health practitioner. It is also up to practitioners to inform health consumers under their care what they can expect from that practitioner, taking into account the principles in the Code of Health and Disability Consumers' Rights.

6. Could RAs have a mandated role in health professional's pastoral care? If so, how can they carry this out?

The Council supports in general a role in pastoral care of practitioners, bearing in mind that its primary focus must be the protection of the public. In this respect it sees that pastoral care could occur in several ways

(a) **Nurses with mental or physical conditions.**

The Council has a large number of nurses who are due to be considered for health concerns (42) and 66 nurses who are being actively monitored because they have a health condition and have conditions included in their scope of practice. There are a further group of nurses who have been suspended from practice and have not applied for that suspension to be revoked. The Council has made suggestions in the attached document - **Operational Functioning of the Act**, under “Fitness to Practise” that would better support these practitioners but would also support some amendment to the Act that would enable it to provide support and pastoral care to nurses who are unwell and/or under stress. This could be along the lines of the support provided by **Nursing and Midwifery Health Program** in Victoria. A similar programme is provided for medical practitioners in Victoria. This programme was jointly funded by the Nurses Board of Victoria and the union but is about to lose funding. The CEO of that program reports that there are a large number of self referrals to that program. It would be possible that, in conjunction with the RA such a programme would be able to provide better protection for the public as well as supporting practitioners to remain in practice.

(b) **Practitioners registered from overseas**

The Council is aware that some nurses who have registered in New Zealand from overseas, particularly where they have practised in countries with a very different health system struggle in New Zealand in the early stages of their practice. The Council is currently consulting on an adaption programme which it intends to operate as a means of ensuring these nurses are provided with the knowledge and skills required to practise in New Zealand and that this will replace the Competence Assessment Programmes used jointly for New Zealand nurses returning to practice and overseas registrants. The Council is of the view that the current Act permits the introduction of such a programme under sections 12(b) and 19(5)(a) of the Act and no legislative amendment is required.
(c) *Maori and Pacific nurses*

The Council supports increasing the health workforce for Pacific and Maori health practitioners generally. The Council submits that it would assist the authorities if the Act provided a specific mandate for RAs to require educational institutions to specifically focus on recruitment and retention of Maori and Pacific students and registrants. The Council has accredited and monitors some specific nursing programmes that cater for Pacific and Maori students. These programmes must meet the same requirements and standards as other education programmes but also provide specific cultural support. Early results indicate that these graduates have been very successful with health consumers, but the numbers are still very low.

**Consumer focus**

The Council agrees that the consumer-focused legislation such as this requires access to necessary information to make good decisions about health practitioners. Although the legislation is omnibus legislation, the professions it regulates are very diverse in nature. In some instances, particularly nursing, health consumers will not have the ability to make decisions about individual nurses providing care. In that regard there is an even greater responsibility on the regulatory authority to ensure that it is ensuring that practitioners are fit and competent to practise, and that the authority is able to have open communication with employers and nurses that will enable all to act as a team in managing a nurse’s practice. Practitioners registered with other regulatory authorities may be made up of self-employed practitioners where the health consumer is in a better position to make decisions about which health practitioner to engage.

**Discussion questions**

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

The Council supports consumer involvement across the broad spectrum of regulatory activities. Some consumer participation is already mandated under the Act, in the makeup of Boards, the Health Practitioners Disciplinary Tribunal and professional conduct committees. The Council also ensures that there is lay representation on committees outside of the Council with delegated powers to review competence and fitness to practise.

There is a difference between lay and consumer representation and it would be helpful if the Act made this clear and required consumer representation in all decision making for delegated powers.

Under the Act the ability to inform people who notify the authority of health or competence concerns regarding a practitioner is limited. This is the case whether the notifier is the employer, another health practitioner or a consumer. The Council would support the introduction of changes that would require the authorities to inform any notifier of the outcome of the health or competence notification as in section 81(1)(c) of the disciplinary provisions.
8. Is information from RAs readily available, particularly as it relates to practitioners and the transparency of complaints and complaints processes? If so, is this information made good use of by the public?

The Council submits that it would be useful to have clarity around when information can be public. The Council strongly supports anything that discloses a practitioner's mental or physical condition remaining confidential as practitioners have the same right to this remaining confidential as any other health consumer (see Operational Functioning of the Act, under "Fitness to Practise" for detailed submissions on this issue).

The right to know when a practitioner has restrictions in his or her practice must be balanced against the rehabilitation focus of the Act. The public's right to know this information differs across the professions as the degree of public engagement with the practitioner's registration differs. An example of this is in midwifery where women are making choices about a partner to work with for their pregnancy and delivery. These consumers are more likely to seek information about individual practitioners. Consumers do not generally have the same choices about nurses providing care.

In the Council's view the Act adequately addresses the requirement to have the register available to the public but further education for the public may be required regarding practitioners' rights and the authority's role in ensuring only those practitioners who are competent and fit to practise hold a practising certificate or have conditions that ensure they are practising safely.

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

The role of the layperson is a critical role in the maintenance of public safety. In the Council's view the role of laypeople is primarily to represent consumer interests rather than the interests of the profession. The Council supports the appointment of laypeople against a skill set to ensure that consumer interests are to the fore in all decision making. In the United Kingdom there is a trend for Regulatory boards to have a 50/50 professional/consumer representation but there does not appear to be any evaluative literature to support this proportion. In the Council's view the skill set is the most important feature as it is for any appointment. A recent report on the Nursing Council from the Council of Healthcare Regulatory Excellence notes:

"...Competency based appointments are in our view an essential element in the modernisation of professional regulation. The election of members of boards from the professions means that people are appointed as representatives of their profession not guardians of patient safety. They may or may not be capable of fulfilling the governance and public protection role which they must take on. Good governance requires both open competition for appointment and selection against defined role description and competencies.

We do not find the process of ministerial appointments either transparent or fair. It does not accord with our understanding of best practice in public appointments. While we understand that it is the New Zealand practice for appointments to be made by ministers we believe this should be done following open recruitment and interview against published competencies.
In accordance with the HCPA Act the election of the Chair and Deputy Chair is on an annual basis from within the Council. We consider that this is also not good practice. The skills and competencies required of a Chair are not the same as those required of a Council member and good practice is increasingly that Chairs should be appointed separately. We consider that there should be defined role descriptions and competencies for the Chair and Deputy Chair. The one year period of office for the Chair is also quite inadequate as it hinders their ability to become fully effective and limits their ability to provide strategic leadership. We consider that chairs should have a period of office of three years. Additionally, the possibility that the Deputy Chair might be elected Chair in the future also introduces unhelpful rivalries and risks creating cliques within the Council. The combination of election with very short terms of office does not allow for proper succession planning. Quite where the patient and public interest lies in this model is unclear to us...”

(A review conducted for the Nursing Council of New Zealand, October 2012: Council for healthcare regulatory Excellence)

In nursing it is important to have a Board membership that includes professionals from different clinical settings and from the education sector to provide an understanding of the breadth and depth of nursing practice and the education required to support that practice. In the Council's view the current structure of 6 professionals and 3 laypeople works well.

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

   The Council would support the introduction of consumer forums and has already commenced a process for more formal engagement with consumers. The Council is aware that other authorities have this process in place. It would be useful for this communication to be across authorities.

**Safety focus**

The Nursing Council agrees that the functions of ensuring practitioners are fit and competent to practise safely is a shared responsibility, not only between the regulatory authority and the employer, but also with the health practitioner. As set out in the discussion document, one of the key values underpinning the HCPA Act is the accountability of the individual health practitioner for their own practice. In the regulation of nursing, where the majority of nurses are employed, neither of these parties is singly able to be responsible for the safety of the public. It must be a shared responsibility.

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

   The Council is of the view that it is making the best use of the legislation to keep the public safe and that this Act, along with other Acts, protects public safety.

   The Council uses all the fitness to practise and complaints processes under the Act to support public safety. Although the number of nurses who have been the subject
of these processes is statistically low, the number is significant in terms of public safety.

**Conduct**

PCCs appointed by the Council have completed 107 investigations into nurses' conduct since the Act came into force and there are 50 complaints nearing completion making a total of 157. Of the 107 investigations completed the PCC has prosecuted 31 nurses for conduct issues. It has also prosecuted 23 nurses who have court convictions that reflect adversely on that nurse's fitness to practise. No further action was taken for 32 nurses and 14 nurses were referred for a review of their competence. Of the 107 nurses, 12 received a letter of counsel, 2 had a review of their scope of practice and conditions included and 16 were referred for a review of their fitness to practise.

**Health**

There are 42 active notifications about health where the nurse has been reported to the Council, generally by his or her employer, and is scheduled to meet with a Health Committee. The Council is actively monitoring 66 nurses who have conditions in their scope of practice and are required to provide employer reports or other monitoring. The Council has 209 inactive files where a nurse has had his or her registration suspended and has chosen not to ask for a review of that suspension or has conditions included but is not practising. The Council also has 320 closed files for nurses who have had no further action taken on the notification (a small proportion), and nurses who have had their conditions revoked.

**Competence**

There are 41 open competence notifications about nurses, and 78 nurses who are being actively monitoring following competence orders being imposed. There are 389 closed files for nurses who have either completed the orders or who have chosen not to continue practising following the notification.

The Council is of the view that the legislation works well in protecting public safety.

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

Of the 157 complaints about conduct received by the Council 125 were received from employers where, almost invariably, the nurse had resigned or had been dismissed as a result of the conduct complained of.

This is also the case for nurses who have been referred for a competence review. Where a nurse has performance or competence issues but the nurse and employer is actively engaged in a performance improvement process, the Council will not take any action, unless the nurse resigns, is dismissed or is not compliant with the processes in place to improve his or her competence.

Prior to the introduction of the Act the Council was made aware of a significant number of nurses who had moved employment several times because of competence issues but where the Council was unable to take any action because the conduct did not meet a threshold of seriousness to take disciplinary action.
Under the Nurses Act the Preliminary Proceedings Committee could either take no further action or refer the conduct as a charge of professional misconduct, which was unlikely to succeed.

The Council, employers and the public all welcomed the introduction of the HPCA Act as it gave the Council the power to review the competence of those nurses and ensured that employers informed the Council of performance concerns that had a direct impact on public safety.

In the area of health the Council also supports employers to monitor and support practitioners where the nurse is still employed and only takes action where the nurse resigns, is dismissed or is not complaint with any processes put in place to support the nurse and protect the public.

The Council is therefore of the view that employer-based risk management systems would not protect the public as the majority of the practitioners are no longer employed and will be seeking employment elsewhere. One of the reasons why mandatory reporting was introduced in this Act for competence concerns was to ensure that employees who has been dismissed or resigned for reasons relating to competence were reported to authorities.

Previously some employers would not or believed they could not take any further action once an employee had left their employment. Some employers reported that once an employee had left their employment they had been advised that they were precluded from notifying the Council of their concerns because of an employment settlement that had been reached. The mandatory reporting provisions make it clear that they are required to notify the authority. It is unclear how public safety could be protected if this legislation, including mandatory reporting was not in place.

Employers are also reluctant to continue with any investigation into a practitioner's conduct once that employee has left the organisation as the cost outweighs the benefit to that employer.

The Council is aware that the corporate division in some organisations discourages professionals from reporting poor practice to avoid lengthy discipline processes and/or public attention on practice issues in their organisation. This also applies to some smaller privately run facilities.

In the Council's experience a complaint may be made by professional staff and then withdrawn once legal advice has been obtained or where there has been an employment settlement. This manages the risk for the organisation but leaves the public at large at risk.

The Council also notes that a lot of employers do not have the resources or ability to ensure that practitioners, particularly overseas applicants for registration, have the qualifications and competence to practise in the New Zealand context, and are fit for registration. Assessing overseas qualifications for equivalency and fitness to register is a complex activity requiring resources and access to other jurisdictions that will be outside the reach of a significant number of employers.

13. What more need to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?
The Council does not believe that there are significant gaps in the legislation other than those identified in its submission on the Operational Functioning of the Act.

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

As discussed above the Council agrees that consideration needs to be given as to which professions need to be regulated and whether some practitioners, who practise under direct or very close supervision of other practitioners, require regulation at the same level as other professions who practise autonomously and who are at greater risk of doing harm if they are not fit and competent to practise safely. Consideration also needs to be given to the actual risk that a practitioner’s practice poses to a health consumer and whether that risk requires the same degree of regulation.

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

The hallmark of a professional is the ability to self-manage and to ensure that their practice is moderated by other professionals and peers. There are a variety of ways that the regulator can ensure that each practitioner is managing his or her risk appropriately by ensuring they are maintaining competence and providing evidence of peer review of their practice. The individual practitioner, regulator, and professional organisations all have a role to play in managing risk.

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?**

The Council is aware that there is research available on risk profiling for medical practitioners, but is of the view that for most nurses the chance of recidivism in the area of complaints is very low.

Practitioners referred for health may relapse in their recovery but the Act provides for processes to deal with further notifications and profiling would be of very little value.

**Cost effectiveness focus**

The Council agrees that a balance needs to be reached between regulation and costs. However it is of the view that the safety of the public is paramount. It also agrees that consideration needs to be given as to which professions need to be regulated and whether some practitioners, who practise under direct or very close supervision of other practitioners, require regulation at the same level as other professions who practise autonomously and who are at greater risk of doing harm if they are not fit and competent to practise safely.

In terms of the cost of practising certificates the Council notes that the fact that employers of a significant number of nurses pick up this cost of regulation is because of an industrial agreements between the employer and employee.
17. **What role do RAs play in considering the cost impacts of their decisions and the cost benefits of regulation?**

This role is articulated well in parts of the current Act and the Council believes that authorities have a major responsibility in considering the cost impacts of their decisions. It notes that in prescribing qualifications under section 13 it must be guided by several principles including the principle that the qualifications must not impose undue costs on health practitioners or on the public. The Council submits that this principle could be applied to the whole Act and either included in schedule 3 or within the body of the Act.

The Council is very conscious that in making any decisions it is supported by public funds and that in doing so it has a responsibility to ensure that costs are minimised and justified. RAs are assisted in this by the Regulations Review Committee review of fees increases and by yearly audits.

In making fitness to practice decisions the RA should be assessing the risk/cost benefit. The Act provided individual practitioners with the opportunity to seek a review of decisions (if there are significant costs involved in completing further education for example).

PCCs should take into account whether the desired outcome of an investigation could be accomplished by some other means and are referred to the Crown Law Prosecution Guidelines to assist in this decision.

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

As submitted in the submission on the Operational Functioning of the Act the Act should be consistent throughout in setting out the grounds for taking action.

The Council is aware that RAs have developed a standard framework for risk of harm and serious risk of harm but notes that the framework would be applied differently for each profession.

The Council would support the inclusion of definitions of risk of harm and risk of serious risk of harm as at page 17 of the discussion document. The Council uses this risk framework in considering what action should be taken in any event.

19. **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?**

In the discussion document it is stated that if practitioners are under the HPCA Act they are "strongly regulated". The Council does not agree with this characterisation and notes that it has been working actively towards light touch regulation for some time (as promoted by the Council for Healthcare Regulatory Excellence). It has actively engaged with employers on the management required from the Council and what is appropriate for the employer and nurse and professional organisation to manage. Feedback from employers and the profession has been positive and the Council believes it has achieved a balance between managing the risk to the public, professional accountability and non statutory regulation.
An example of this is the introduction of the expanded practice framework where the regulator provides the guidelines and leaves the implementation and decision making to the practitioner and employers.

The Council notes that the proportion of nurses who are actively regulated or managed is a very small proportion of the number of nurses who hold practising certificates. For competence it is 0.14% of the nurses with practising certificates, and for health notifications and complaints the proportion is even lower. This is a good indicator of successful light touch regulation.

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

The Council is only able to comment on whether or not the regulation suits the nursing profession and believes that it is appropriate for the regulation of nurses.

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

There is always room for improvement. The Council has recently been audited by CHRE and is currently reviewing its competence review process and implementing changes to its health process (fitness to practise). It has introduced on-line annual practising certificate renewal and on line registration for New Zealand graduates. Further improvements are planned. There is nothing in the current Act that prevents improvement of the administration of the Council’s functions other than the suggested amendments in the submission on the Operational Functioning of the Act.

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

The Council notes that section 14 could include an overt requirement to consult with the public. There may be other avenues for consultation that should be mandated, such as Codes of Conduct etc. The Council already consults extensively with relevant stakeholders including the public and there is nothing in the Act that prevents this consultation. However, if this consultation is not occurring then it may be desirable to require broad consultation in other areas as well.

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

The Council supports the model of the Health Professionals Council in the UK where a number of smaller professions are regulated by one Board.

The CHRE have just completed a review of the cost effectiveness and efficiency of Health Regulators in September 2012 which is as yet unpublished. The Council notes that one of the findings of that report is that the urge to deliver efficiency savings must not lead to a fall in the quality or effectiveness of regulators’ performance.
24. **What is the ideal size of RA boards?**

For the Nursing Council a board of 9 works well but notes that it has delegated the majority of decisions about individual nurses to either the Registrar or to Committees outside of the Council, retaining, as it is required to do, the role of reviewing delegated decisions.

The Council notes that CHRE have published a paper on Board size and Effectiveness in September 2011, available on its website. In this report the CHRE notes that a board size of 8-12 members is associated with greater effectiveness.

In the Council’s view it is of greater importance to have the requisite skill set and competencies in place for board membership and the Council has developed a document to assist with these appointments.

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

The other issues the Council wishes to address are in its submission on the *Operational Functioning of the Act* (Attachment 1).
Attachment one

Operational functioning of the Health Practitioners Competence Assurance Act 2003

26 October 2012
1. Introduction

The Nursing Council previously submitted on the review of the Act that occurred in 2008/2009. A number of its submissions were accepted and recommendations that required legislative amendment were included in Review of the Health Practitioners Competence Assurance Act 2003 – Report to the Minister of Health by the Director General of Health June 2009.

Part 1

The Council supports the amendments as they were proposed and further submits on recommendation 33. The Ministry indicated in July 2011 that this recommendation may not be adopted.

Part 2

The Council also wishes to submit on suggested amendments that were not adopted as recommendations in the 2009 review that would improve the operational functioning of the Act or that impact on the principles of natural justice (or fairness) that underpin the Act and further amendments identified since the previous review.

Part 1

2. Proposed legislative amendments

2.1 Recommendation 18

That section 114 of the HPCA Act be amended to give the Minister the power by order in Council to join and restructure two or more existing authorities and/or add other practitioner groups to an existing authority in situations where, after consultation, the Minister is satisfied that it is in the public interest to do so and the authorities and their professions are generally in agreement.

The Council notes that this amendment was proposed and consulted on during the review. At the time of the proposed amendment the issue before the regulatory authorities was the expected proliferation of new regulatory authorities as there were a large number of professions applying for regulation under the Act. It had been identified that the Minister was not able to amalgamate authorities under section 114 but was only authorised to add one profession to another or create a new authority. The Council supports the amendment in its proposed form, noting the requirement for consultation and general agreement.

2.2 Recommendation 19

That sections 64 and 118 of the Act be amended to specifically recognise that it is a function of responsible authorities to receive complaints about the
appropriateness of a practitioner’s conduct and to protect complainants against civil or disciplinary proceedings unless they have acted in bad faith.

The Council notes that the Act currently does not provide a right to make a complaint to the Council where the conduct complained of has not affected a health consumer. A health practitioner may be investigated for conduct which does not directly affect a health consumer but which may reflect on the practitioner’s fitness to practice, or which may bring or is likely to bring discredit to the profession.

The Council also supports the amendment that provides the same protection for complainants as is provided to witnesses under section 76 and notifiers of health (section 45(6)) or competence issues (section 34(4)).

2.3 Recommendation 20

That section 68(2) of the Act be amended to give responsible authorities discretion over whether to refer practitioners who have been convicted under a minor offence listed in section 67(b) to a professional conduct committee.

The Council welcomes the proposed amendment but notes that in its original submission it submitted that the discretion should be for convictions under section 67(a) and (b). Subsection (b) captures drink driving offences and careless driving causing injury which can incur a penalty of imprisonment for a term not exceeding 3 months. It notes the finding of the report that any conviction under section 67(b) that could incur a penalty of 3 months imprisonment was unlikely to be considered minor. The Council further submits that authorities should have discretion as to whether these convictions under section 67(b) warrant referral to a PCC.

The PCC appointed by Council to consider convictions has adopted policies on which nurses will be referred for a review of his or her fitness to practise, but because of the mandatory nature of the referral these nurses must be provided with the opportunity to meet the PCC and then to be reviewed for fitness to practise. If the Council wishes to include any condition in a nurse’s scope of practice or suspend a nurse’s registration the Council is required to provide the nurse with a further opportunity to meet, thereby adding to the cost of regulation with no added protection of public safety. A discretion in this section for all convictions would allow these practitioners to be referred directly for a review of fitness to practice, or for the authority to issue an education letter without having to refer the practitioner to a PCC for a minor conviction.

The Council is not aware of any prosecution before the Health Practitioners Disciplinary Tribunal (HPDT) for drink driving offences alone. A PCC has referred two nurses to the HPDT with drink driving convictions but both had more serious convictions or conduct issues that led to the referrals. It is of the view that a rehabilitative approach is appropriate for this group. The practitioners have already been punished in the criminal court for the offending. Therefore the authorities should have discretion as to whether practitioners should be referred to a PCC.
Since 2004, when the Act came into force, the Council has considered 124 nurses with drink driving convictions. Of those convictions 26 have been referred for a review of their fitness to practice, 64 have received a letter of counsel and for 32 no further action was taken on the conviction. All of those nurses have had to be referred to a PCC and scheduled a meeting with a PCC. Although the Council has a PCC that meets 3 monthly to consider all convictions there are still significant costs, and stress for the nurse. The current approach is required because of the mandatory requirement of section 68(2).

Alternatively the section could be amended so that the threshold for reporting by the Court Registrar and referral to a PCC is imprisonment for more than 3 months.

2.4 Recommendation 21

That sections 69 and 93 of the Act be amended to restrict interim suspension to situations where there are reasonable grounds to believe that a practitioner’s conduct poses a risk of harm to the public.

The Council supports this amendment in the interests of clarity and the premise that the grounds for interim suspension within the Act should be consistent across all of the provisions within Part 3 and Part 4 of the Act.

2.5 Recommendation 22

That paragraph 17 of Schedule 3 of the Act be amended to allow the responsible authority to delegate any of its functions, duties or powers to a committee.

The Council also supports this proposed amendment as there is no reason why the functions under sections 69 and 71 cannot be delegated to a person or committee. It notes that all delegated decisions can be reviewed by the full authority and that a delegation can be revoked at any time. The delegation does not prevent an authority from exercising the function or power itself. The Council is satisfied that, provided it ensures there are robust reporting policies and processes in place there is no reason why all functions duties and powers cannot be delegated. It notes that where a power is delegated the opportunity for review (under clause 18) provides an affected practitioner with an additional opportunity to challenge a decision, not available where there is no delegation. In those circumstances the practitioner’s only recourse may be to appeal a decision under section 69 to the District Court with additional expense to the practitioner and authority.

2.6 Recommendation 23

That section 95 of the Act be amended to allow the chair of the HPDT to issue, on his or her own, an order for non-publication of material in circumstances where all parties to a hearing consent to the non-publication order.
This is the process currently adopted by the HPDT and the PCCs. To operate otherwise would result in a significant increase in hearings costs as the Tribunal would have to convene to consider applications for name suppression pending a hearing.

2.7 Recommendation 24

That section 102 of the Health Practitioners Competence Assurance Act 2003 be amended to enable the HPDT to set a minimum period within which a health practitioner whose registration has been cancelled cannot apply for reinstatement.

The Council fully supports this amendment. In the last two years it has received enquiries about applying for reinstatement from nurses before the Council has even had the opportunity to implement the HPDT order for cancellation of registration and has received applications for reinstatement within 3 months of the order for cancellation. Although the Council has chosen not to reinstate the applicants there is a significant cost involved in convening a meeting to consider the application as the applicant must be provided with a reasonable opportunity to provide oral and written submissions on the application. The Council has increased the cost that must be borne by the applicant in the interests of cost recovery but must ensure that any cost imposed is not prohibitive. Where there is no time set for cancellation, ostensibly the most serious penalty, this penalty could be perceived as less serious than suspension which can be imposed for up to three years. Setting a minimum time before reinstatement can be applied for would also provide an indication of the seriousness with which the HPDT views the conduct that incurred cancellation of registration.

2.8 Recommendation 25

That section 103 of the HPDT Act be amended to give the HPDT the power to instruct the appropriate executive officer of the Tribunal to notify any employer of an order of the Tribunal if the Tribunal is satisfied that such disclosure is in the public interest.

The Council fully supports this amendment. There have been two occasions recently where nurses have had conditions included in their scopes of practice but where the employer was unaware of those conditions until the nurse’s annual APC was issued. Employers of nurses generally check that a nurse had an APC annually and rely on nurses to inform their employers where any conditions are included. Unless the employer is continually checking the authority’s website or the HPDT website it may be possible for a practitioner to continue practising while suspended (see Singh 475/Nur12/212P) or to practice without conditions that have been imposed in the interests of public safety. Although practitioners are required to inform the authority of their residential and work address under section 140 this requirement is not strictly adhered to and there is no penalty for not promptly informing the Council of any change.
2.9 **Recommendation 27**

That section 104 of the Act is amended to clarify that responsible authorities are responsible for the running costs of the HPDT including costs not directly related to individual hearings and the costs of training Tribunal panel members.

The Council fully supports this amendment and notes that training is essential to ensure good decision making.

2.10 **Recommendation 32**

That a definition be added to section 5 of the Act so that it is clear that the term “emergency” includes prolonged emergencies.

The Council fully supports this amendment.

2.11 **Recommendation 33**

That section 12 of the Act be amended to clarify that responsible authorities have the power to revoke an educational institution’s accreditation after consulting with any party that is directly affected by changes.

The Council fully supports this amendment. The Council is aware that the Ministry has recently resiled from this recommendation and has informed the Council that the power to revoke such an accreditation is implicit in the Act and did not require legislative amendment or that the Council should accredit and revoke accreditation using the prescribed qualifications that are gazetted.

The Council is of the view that an authority cannot be expected to rely on an “implicit” power to take the significant step of revoking the accreditation of an educational institution, nor should this occur merely by gazetting qualifications from accredited institutions.

Under section 36(3) of the Nurses Act 1977 the Council could revoke the approval of a school of nursing with the concurrence of the Minister, an opportunity to respond to a proposal to revoke the accreditation with appeal right to the High Court. The transitional provisions of the Act (section 224) permit the Council to revoke the accreditation of educational institutions already accredited under the old Act, but there is no such provision for schools of nursing accredited after the introduction of the Act.

Although there has only been one new educational institution accredited since the Act came into force the ability to monitor is only effective if the Council is also able to revoke accreditation and there should be no distinction between institutions approved before and after the Act came into force. Although any decision to revoke accreditation could be the subject of Judicial Review proceedings the Council would support the introduction of the right to appeal such a decision to the High Court.
2.12 Recommendation 34

That section 15 of the Act be amended to give responsible authorities the power, when necessary, to recognise New Zealand qualification as equivalent to qualifications that have been prescribed under section 12.

The Council supports this amendment.

2.13 Recommendation 36

That section 17(4) of the Act be amended to include fines and costs imposed on practitioners by disciplinary findings under the relevant former legislation on professional registration.

The Council supports this amendment and notes that a number of applicants for reinstatement have applied many years after cancellation of their registration, having made no attempt to pay fines or costs imposed by the Nursing Council. The Council has implemented a very fair payment plan for former registrants to ensure that that payment is possible for those applicants not indemnified but some applicants have chosen not to make any contribution. The current Act only permits the Registrar to decline reinstatement if the fine was imposed by the HPDT.

2.14 Recommendation 37

That section 49 of the Act be amended to allow a responsible authority to require an examination by medical practitioner or appropriate health practitioner.

Increasingly with the ageing workforce the Council is considering nurses who are reported because of cognitive impairment secondary to dementia, CVA, alcohol or drug abuse a mental illness of long duration, or impairment secondary to a debilitating physical condition. The Council may have already received a medical assessment but requires more information about the nurse’s ability to practise than a psychiatrist or physician is able to furnish. These specialists often suggest cognitive testing by a neuropsychologist or an assessment by another health practitioner to determine the nurse’s ability to carry out the physical functions of nursing or it may be obvious from the notification that such an assessment will provide the best information to make the right decision. Under the current Act the medical practitioner may consult any other health practitioners he or she considers able to assist in the completion of the examination or test, but the Act does not allow the Council to require a nurse to submit to cognitive testing or other testing without an examination by a medical practitioner. As it stands the provision removes flexibility and increases cost.
3. Part 2 Other legislative Amendments

3.1 Section 8 - Unqualified person must not claim to be health practitioner

Although section 8 provides that health practitioners must not practice without a current practising certificate there is no penalty that can be imposed for practising without a practising certificate under this section. The only way a penalty can be imposed is to frame a charge under section 100(1)(d) of the Act. This process is time consuming and expensive.

There are a significant number of nurses each year who have inadvertently practised for varying periods of time without practising certificates but where this conduct does not warrant a disciplinary charge or penalty (159 since the Act came into force). The Council submits that it would be more cost effective and appropriate if section 8 provided for a fine that amounted to a minimum of the amount that the practitioner has omitted to pay up to a capped amount (different for each authority) as deterrence.

Authorities can refer these practitioners to the Ministry of Health under section 7(2) of the Act which provides that:

(2) No person may claim to be practising as a health practitioner of a particular kind ... unless the person-

... 

(b) holds a current practising certificate as a health practitioner of that kind.

(5) Every person commits an offence punishable on summary conviction by a fine not exceeding $10,000 who contravenes this section.

Council's experience is that the Ministry is unlikely to take any action on the nurses who have inadvertently practised without a practising certificate, and believes that it is not an efficient use of the Ministry's resources for it to do so. The Council has taken disciplinary action where a nurse has deliberately practised without a practising certificate or has practised when his or her practising certificate has been suspended.

The Council supports an amendment to permit the Council to impose a fine that will mean there is no advantage to a nurse to practise without an APC and that will act as a further deterrent. Under the Nurses Act 1977 the Council was able to require payment for the time that a nurse did not practise without a practising certificate but the current Act does not permit retrospective payment. This leads to a situation where nurses are in a better position financially by failing to renew their practising certificates.
Registration

3.2 Section 16 Fitness for registration

(h) the responsible authority has reason to believe that the applicant may endanger the health and safety of members of the public.

Council submits that the threshold for the general provision for not registering an applicant is too high and may be difficult to establish. The Council notes that an applicant who has received diversion or has been discharged without conviction by the Court for a dishonesty offence may have conducted themselves in a manner that reflects adversely on that person’s fitness for registration. However it may be difficult to decline registration on the basis that the applicant’s registration would endanger the health or safety of members of the public. The Council is of the view that the more appropriate wording for this catch all provision, that would better protect public safety, would be that the authority has reason to believe that the applicant’s conduct reflects adversely on his or her fitness for registration.

3.3 Section 19 - Authority may obtain information about application

When a former practitioner who has had his or her registration cancelled following a disciplinary order applies for reinstatement the Act does not provide for the PCC or the complainant to provide information to the regulatory authority that is considering reinstatement. With the increased consumer focus identified in this review the Council submits that the PCC and/or complainant should be provided with a reasonable opportunity to make written submissions and be heard in respect of any such application. The current provision only permits the provision of information if the authority thinks fit.

Issuing practising certificates

3.4 Sections 28 and 29

One of the most important functions of the Act is ensuring that nurses who are practising have maintained the requisite level of competence to practise safely. In considering whether to issue practising certificates under section 27 of the Act, the Registrar considers whether the applicant has practised sufficient hours, completed adequate professional development to support that practice and has had his or her competence assessed in the preceding 3 years. In order to monitor compliance with the continuing competence requirements the Council may issue a practising certificate with a condition that the nurse must complete practice hours or professional development within a certain time frame.

Under section 29(2), in order to satisfy the criterion in section 29(1), the Council may include new conditions in the applicant’s scope of practice or may vary existing conditions in that scope of practice. Under section 28(2) if the authority
proposes to include or vary conditions it must give the applicant a reasonable opportunity to make written submissions and be heard, either personally or by his or her representative, in respect of the application.

The Council would include conditions regarding practice hours or professional development for over 100 nurses every year and it is impractical to offer each of these nurses the opportunity to submit and be heard on the matter.

The Council submits that for continuing competence requirements the Council should have discretion as to whether it provides an opportunity to be heard on the issue. A delegated decision is able to be reviewed under clause 18, schedule 3 of the Act if the applicant believes the delegated decision was unfair.

Competence provisions

3.5 Section 35 - Authority must notify certain person of risk of harm to public

The Council's view is that the mandatory provision requiring authorities to notify all those listed in s35(1) should be amended to allow an authority to only notify certain of those agencies of the risk of harm. This would allow for greater flexibility as the Council generally uses this provision to notify an employer of the nurse to protect public safety. It is unclear whether this provision relates to practitioners under health, competence and discipline processes under the Act. As the section is under Part 3 it could be argued that it only relates to the fitness to practise and competence provisions but the section is ambiguous.

3.6 Section 38 – order concerning competence

The Council submits that under section 38(1) the authority should also be able to suspend the registration of a practitioner, particularly if a practitioner does not participate in the review process, or if the practitioner has already been the subject of a previous review and has failed to maintain competence standards after previous orders ceased to have effect because a review was completed or an assessment has been completed successfully. The practitioner would then be required to satisfy the authority that there are no competence issues before the suspension is revoked.

An authority is able to suspend a practitioner's practising certificate under section 39(2(a) but the main purpose of that section is to order Interim suspension pending a competence review and that the order ceases to have effect once the practitioner has attained a pass in an examination or assessment specified in a order under section 38(1(c). This implies that in order to suspend a practitioner's practising certificate following a review the authority must make an order that the practitioner sit an examination or assessment, when the authority may prefer to make one of the other orders set out in section 38(1).

There should be right of appeal against any decision not to revoke a suspension (see para 3.11 below).
Fitness to practise

3.7 Section 45 - Notification of inability to perform required functions due to mental or physical condition

The Council submits that this section should explicitly provide that practitioners are required to declare their own health condition to the authority as the wording that a health practitioner is required to notify about a health practitioner is unclear. The Council also submits that the wording "unable to perform the functions required for the practice of his or her profession because of some mental or physical condition" is confusing. The Council fields a significant number of calls from employers, the public and the profession as to the meaning of those words and what the appropriate threshold is. The section could use the wording of section 34 for consistency across the Act as below:

(2) "If a person to whom this section applies has reason to believe that a practitioner's practice may pose a risk of harm to the public because of a mental or physical condition the person must promptly give the Registrar of the responsible authority written notice of all the circumstances"

3.8 Section 48 Interim suspension or inclusion of conditions

The Council submits that this interim suspension or inclusion of conditions should apply until the practitioner is provided with the opportunity to make written submissions and be heard on the matter (under section 50(b) of the Act) and the authority has made orders under section 50(3) or (4). Under the current provision the interim suspension can only be extended if necessary for examination or testing under section 49 which implies that the suspension is only in place until that testing has taken place, not until any orders by the authority regarding practice are imposed.

Although the Council meets fortnightly with nurses it is not possible or fair process to schedule a meeting directly after the examination or testing. The Council submits that, in the interests of public safety, the suspension should be in place until the authority has considered the report and provided the practitioner with a reasonable opportunity to be heard on the notification. If the medical report does not identify a mental or physical condition the suspension would be revoked. The Council uses this provision sparingly and only for the more serious notifications where there are public safety risks.

3.9 Section 50 - Restriction may be imposed in case of inability to perform required functions

Under section 50(4) an authority may order that conditions be included in a practitioner's scope of practice if satisfied that the practitioner is able to perform the functions required for the practice of his or her profession, but only if those conditions are observed. The Health Committee of the Nursing Council uses this section extensively to allow nurses with mental or physical conditions to practise. Some of the conditions imposed, which may include random drug screening or testing for alcohol abuse are conditions that identify the nurse's mental or physical
condition. Section 32 of the Act requires an authority to endorse on every annual practising certificate the practitioner’s scope of practice. This includes conditions in the practitioner’s scope of practice and under section 138, 139 and 149, this information is available to the public. The Council is of the view that information that identifies a practitioner’s health condition is private health information that should not be publically available and that legislative amendment should enable authorities to impose confidential conditions that are only available to the practitioner, employer and other overseas regulatory authorities.

The Council is aware that other regulatory authorities deal with this issue by using voluntary undertakings to monitor practitioners but the Council is of the view that for nurses this is impractical and does not fulfill its obligations under Trans-Tasman mutual recognition legislation. Under this legislation AHPRA is able to impose conditions that have been imposed in New Zealand to maintain public safety but voluntary undertakings are not able to be imposed.

The Council believes that this amendment would improve the pastoral care of practitioners and would provide support to these practitioners to return to practice after a period of ill health without revealing their mental or physical condition to the wider public and colleagues. As long as the authority, the practitioner and his or her employer are fulfilling their obligations of protecting the public by only permitting practitioners to practise when well enough to do so, then there is no need for members of the public to be informed of the details of a practitioner’s health.

Anecdotally the Council is aware that nurses are reluctant to declare health conditions because of concerns that this information will be made public. It is only the reassurance that health information that should be confidential will remain confidential that encourages these nurses to declare a mental or physical condition or for other treating health practitioners to notify the Council on their behalf.

3.10 Section 51 Revocation of suspension or conditions

Under section 51(1) of the Act an authority may revoke any suspension it has imposed under section 39 (competence) or section 50 if it is satisfied that the practitioner is again able to practise the profession satisfactorily. The Council notes that the ground for revoking the order differs from the grounds to impose the order (unable to perform the functions required for the practice of his or her profession) and submits that the grounds for both should be able (or unable) to practise safely.

Section 51 does not provide for the very common situation where the authority wishes to revoke a practitioner’s suspension of registration, but include conditions in the practitioner’s scope of practice when the practitioner returns to practice. Suspension of registration is only ordered for practitioners who are very unwell. The authority invariably wishes to include conditions in that practitioner’s practice to support a graduated and supported return to work.

This issue was identified in the recent District Court decision, Rein v PCC of the Nursing Council 11 May 2012, Judge S M Harrop, District Court, Wellington CIV-2011-085-771. In that decision Judge Harrop states:
"In my view, having made the decision in 2003 to revoke Dr Rein’s suspension rather than to allow her to continue to practice but with conditions, the Health Committee arguably and on a plain reading of s 51(1) was required to consider the question of satisfactory ability to practice without reference to the possibility of conditions. It would have been very easy for Parliament to have said in s 51(1) that an order revoking a suspension might be accompanied by a direction that the practitioner’s scope of practice was to include conditions. After all, that power had been expressly mentioned in the preceding section as something which could be done as an alternative to the original revocation. There are no such words in s 51(1).

[29] That said, it would seem, as a matter of principle, odd if the Committee could decline suspension in the first place because a practitioner’s shortcomings could be adequately met by conditions, yet on an application to revoke a suspension it could not place conditions on the scope of practice, and only had the power to revoke or not. It would be most unfair to a practitioner if the Health Committee was entirely satisfied that revocation was justified, provided conditions were imposed, to have that declined because there was no power to impose such conditions.

[30] For these reasons, despite the interpretation of the provisions apparent on a literal reading, I proceed on the basis that the Health Committee could, if it thought fit, have imposed conditions on Dr Rein’s scope of practice as a condition of granting revocation of the suspension.

The Council submits that section 51(1) should be amended to provide for the imposition of conditions following the revocation of a suspension imposed under section 50(3) of the Act.

Section 51 also refers to section 39 which is interim suspension for competence concerns rather than section 48 which is interim suspension for health notifications. It is submitted that section 51(1) and (2) was intended to apply to section 48 rather that section 39 and should be amended accordingly.

3.11 Section 106  Rights of appeal (fitness to practise)

The grounds of appeal as set out in section 106 do not include a right to appeal against a decision not to revoke the suspension of registration under section 51(1) or a decision not to revoke conditions under section 51 (2). The Council notes that subsections 51(1) and (2) also refer to revocations of interim suspension or inclusion of conditions under section 39 of the Act where practitioners may be suspended pending a competence review.

The Council has been the respondent for two recent appeals against decisions of Health Committees not to revoke a nurse’s suspension of registration ordered under section 50(3). The Council did not oppose either appeal on jurisdictional grounds on the basis that the appellants should have a right to appeal those decisions and that the appeal should proceed on its merits.

Judge Harrop in the Rein decision (above) identified the issue as below:
"...in my view there must be a real question as to whether there is jurisdiction to appeal against this kind of decision.

[11] Under s 51(1) the Health Committee “may at any time make an order revoking any suspension that it has imposed under s 39 or s 50 if it is satisfied that the health practitioner concerned is again able to practice the Health Practitioners profession satisfactorily”.

[12] Here, Dr Rein applied for an order revoking her suspension but the Hearing Committee resolved not to alter the status quo. A decision to decline to revoke a suspension is not obviously included within the range of decisions which may be appealed under s 106.

...

On that basis it is not one of the decisions in respect of which there is a right of appeal under s 106(1). A practitioner may appeal against the decision to suspend registration but not, it appears, against a refusal to revoke it. As a matter of practicality, that would appear to be inconsistent and potentially to put a practitioner in a position where, once there is a valid suspension, it is impossible to return to practice even if the Nursing Council is completely unwarranted in maintaining the suspension."

In the very recent decision of Wallis v Health Committee 19 October 2012, Judge S E Thomas, District Court, Wellington CIV-2011-004-002225 the same issue arose. Judge Thomas agreed with Judge Harrop’s analysis and that a decision not to revoke a suspension under section 51 is not one of the grounds of appeal under section 106(1) of the Act. Judge Thomas notes that the Council intends making a submission on the review of the Act and further notes that, “It does seem odd and potentially unjust for a practitioner to have the right of appeal against a decision to suspend registration but not against a refusal to revoke it”

Complaints and Discipline

3.12 Section 77 - Powers to call for Information or documents

This section does not provide a power to summons people to provide evidence or a statement, only to produce papers, documents, records or things. In conducting investigations under the Act PCCs are sometimes met with reluctance by some witnesses to provide a statement. Witnesses can be summoned to attend and give evidence before the Health Practitioners Disciplinary Tribunal (clause 8, Schedule 1) but not before a PCC. As the PCC’s role is to determine whether there is sufficient cogent evidence to frame and refer charges to the Tribunal it should have the power to gather all the relevant information before proceeding with a prosecution. The Council submits that section 77 should be amended to so that the PCC has similar powers to the HPDT.

3.13 Section 80 - Recommendations and determinations of professional conduct committees
Under section 80(2)(c) a PCC may recommend that the Council reviews a practitioner’s scope of practice but does not specify the form of that review. This section has been used successfully by PCCs appointed by the Council to recommend the inclusion of conditions in a nurse’s scope of practice such as completing an education programme on professional boundaries. Where the Council decides to include conditions in a practitioner’s scope of practice the Act requires a further opportunity to make written submissions and be heard on the matter. The Council submits that a PCC should be able to recommend conditions without the need for a further hearing, provided the practitioner has had the opportunity to respond to that proposed action at a meeting with the PCC.

3.14 Section 93 - Interim suspension of registration or imposition of restriction on practice

The Council notes that the grounds for suspension under this provision are “if it is satisfied that it is necessary or desirable to do so, having regard to the need to protect the health and safety of members of the public. The Council submits that the grounds for interim suspension or suspension, other than suspension that is ordered following a disciplinary finding under section 100 and 101, should all be aligned for clarity and consistency. The Council’s preferred option would be where the decision maker is satisfied that there are reasonable grounds to believe that the health practitioner’s practice poses a risk of harm to the public.

3.15 Section 101 - Penalties

This section should be reworded to deal with the issues raised as to whether section 101(1)(c) means that conditions can only be included if a practitioner’s registration has been cancelled or suspended as it refers to “after commencing practice following the date of the order”. The Council is of the view that this provision is so worded to ensure that practitioners do not simply cease practising for the duration the conditions are ordered and then resume practice without conditions. There have been some challenges to this and Council submits that the section should be amended in the interests of clarity.
3.16 Section 147 - Removal of qualification, or cancellation of registration, overseas

This section only permits authorities to suspend or cancel registration but not to include conditions in practice. Under Trans-Tasman Mutual Recognition the Council may impose conditions for the purpose of imposing on the applicant’s registration in New Zealand a condition that applies to the registrant’s registration in an Australian jurisdiction (section 20(3)(b) and section 32 of the Trans-Tasman Mutual Recognition Act 1997) but cannot do so for registrants from other overseas jurisdictions. The Council submits that the section should be amended to permit the inclusion of conditions imposed by overseas regulatory authorities and on the grounds of health or competence not just disciplinary grounds.

The section also does not permit an authority to take action for New Zealand registered practitioners who have their registration cancelled or suspended overseas on disciplinary grounds and that New Zealand authorities need to be able to do so rather than taking disciplinary action with the difficulties and costs involved.

The Council notes that there are a significant number of practitioners who have dual registration with two New Zealand authorities (midwives and nurses and anesthetic technician and nurses). The Act does not allow one or other of the authorities to review the registration of a practitioner who has had their registration cancelled or suspended by another New Zealand authority. This means that two authorities may be forced to take disciplinary action for the same conduct, particularly if the practitioner has been convicted of an offence that reflects adversely on fitness to practise either profession. This means additional expense and the Council submits that this provision should be extended to cover dual registration.

General provisions

3.17 Section 140 - Health Practitioners must notify Registrar of address

The Council submits that practitioners should also be required to ensure that the Registrar has the practitioner’s current email address, where applicable.

3.17 Section 144 - Revision of register

Currently section 144 requires an authority to mail out a request to a health practitioner as to whether the practitioner wishes to have their entry in the register cancelled. The Council currently asks nurses over the age of 80 whether they wish to have their name removed from the register. This amounts to a large number of nurses (approximately 1000) and significant postage costs as a second letter must be sent 6 months later before any entry is cancelled. The Council submits that the section should be amended to allow e-mail correspondence and that a second confirmation is not required. All practitioners are required to inform the authority of
their current address. If a practitioner wishes their name to be restored to the register this can be accomplished under section 145.

3.18 Risk of harm - Serious Risk of harm

Interim orders

The Council notes that there are several processes whereby a practitioner's practising certificate or registration can be suspended or the practitioner can have conditions imposed in the interim but that the grounds of satisfaction called for are very different. The grounds are set out below:

- Under section 39 the authority may suspend the practitioner's practising certificate, change the health services the practitioner is able to perform or include conditions considered appropriate if there are reasonable grounds for believing that the practitioner poses a risk of serious harm to the public (by practising below the required standard of competence).

- Under section 48 the authority may suspend the practitioner's practising certificate, change the health services the practitioner is able to perform or include conditions if the authority considers that the practitioner may be unable to perform the functions required for the practice of his or her profession because of some mental or physical condition.

- Under section 69 the practitioner may have his or her practising certificate suspended or one or more conditions included in his or her scope of practice if the practitioner is alleged to have engaged in conduct that is relevant to a criminal proceedings or an investigation by the HDC or under this Act and in the opinion of the authority held on reasonable grounds casts doubt on the appropriateness of the practitioner's conduct in his or her professional capacity.

- Under section 79 PCCs may recommend suspension of a practising certificate if the PCC has reason to believe that the practitioner's conduct poses a risk of serious harm to the public (the decision is then made by the Council under 69(2) or other provisions but the Council is then considering the appropriateness of the conduct).

- Under section 94 the HPDT may if it is satisfied that it is necessary or desirable to do so, having regard to the need to protect the health or safety of members of the public, order that the registration of the practitioner be suspended or that they may only practise in accordance with conditions.

The Council submits that in the interest of clarity and fairness the power to suspend or include conditions in the interim should be standardised and should adopt the grounds as set out in section 39 of the Act.
Review of the Health Practitioners Competence Assurance Act 2003

Submission to the Ministry of Health

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About the New Zealand Nurses Organisation
The New Zealand Nurses Organisation is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing over 46 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Runanga o Aotearoa comprises our Māori membership and is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals comprising half the health workforce.

The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

EXECUTIVE SUMMARY
1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on this second review (the Review) of the Health Practitioners Competence Assurance Act 2003 (HPCA Act).

2. NZNO has consulted extensively with members and staff in the preparation of this submission, including all membership groups - Colleges and Sections, regional councils, te Runanga and the Board - and all organisers and nursing, policy, research, legal and industrial advisers.

3. We have discussed the document at length with other nursing bodies and other health practitioner groups, and have attended the Ministry's information sessions in Auckland, Wellington and Christchurch.

4. It is apparent that there is a broad consensus across the health workforce that the Act fits the Aotearoa New Zealand context*, is fulfilling its purpose and is working well: the public is safer, practitioners more accountable, and the workforce is more flexible, innovative and integrated because of the far-sighted provisions of the Act. *We note, however, that there is no specific reference to te Tiriti o Waitangi / Treaty of Waitangi in the Act and although RAs are explicitly required to set standards of cultural competence, a commitment to the bicultural
foundation of Aotearoa New Zealand is conspicuously lacking. Ethnic disparities in the health workforce have been shown to contribute to health disparities and a Māori public health workforce development approach would positively influence inequalities in health (Ministry of Health, 2007; Kingi, 2007).

5. The cost of regulation through self-funded responsible authorities (RAs) is reasonable, with independent RAs managing a number of complex, secure processes in a commercially efficient manner, which is subject to the scrutiny of the Office of the Auditor General (OAG).

6. A substantial review at this stage, when many of the logistical challenges of establishing a new regulatory regime have been ironed out and there is clear evidence that it is delivering the flexibility and innovation intended, is counterproductive and wasteful of health sector time and Vote Health money.

7. NZNO has serious concerns about the genuineness of this consultation in the light of misrepresented outcomes from previous consultation on a combined secretariat and amalgamation of RAs (see Appendix 1, for example), and the opaque, muddled content of this document, which lacks evidence, context, and transparency.

8. The last review of the HPCA Act attracted substantive submissions and significant engagement from a wide range of stakeholders at workshops and discussion meetings and endorsed the current view that the Act was generally working as intended. Very few of the recommendations consequential to that review have been acted on and this review appears to be headed in an entirely new direction, without adequate time for consultation.

9. We suggest this is not a good use of either stakeholder or state resources.

10. The 2012 Review's unnecessarily wide purview extends well beyond the Act to encompass broad health workforce and policy agendas.

11. The HPCA Act is not the appropriate vehicle for addressing deficiencies in workforce planning, data collection, or resourcing. Indeed, we would argue that it is the most inappropriate one, since the Act's purpose is to ensure that in the delivery of health care, protection of public safety and assurance of professional standards is independent from employment, policy and resourcing pressures.

12. Shifting the focus of health workforce regulation from the protection of standards for safety and quality to minimum competencies, subject to variation and influence from agencies responsible for health workforce planning and health care delivery, would, in NZNO's view, risk all that
the HPCA Act has achieved. Deregulation risks a significant human burden with the loss of protection for public safety; escalating costs; a more complex and less cohesive environment for the delivery of healthcare; and the loss of public trust in the taxpayer-funded health system.

13. NZNO notes that the Review is seeking information about the broader regulatory environment governing health and safety in the health sector, without describing the current context, including two significant reviews affecting both the setting of standards in the health and disability sector, and workplace safety.

14. We do not feel the review adequately canvasses the factors affecting safety in the health sector; NZNO draws your attention to the most important and relevant of these in the discussion which follows.

15. We note, however, that many of the broader issues around safety are well outside the scope of the HPCA Act and again question the relevance and intent of open-ended questions about health and safety legislation and regulation without the Ministry identifying concerns or being transparent about objectives.

16. There is a lack of precision and clarity around much of the discussion material and questions in the document, precluding the opportunity for discussion within a shared understanding of declared intent (and concrete proposals), though the underlying objective appears directed towards reducing costs, decreasing regulation and government oversight, and increasing the independent role of employers.

17. For this reason, we have responded only briefly to the consultation questions, which are prefaced by some general comments, but would be very happy to be engaged in further discussion and/or development of proposals pertaining to health workforce regulation and safety.

18. NZNO would like a summary of submissions and we are happy for the details of this submission to be published.

19. NZNO makes the following key points in relation to this review that:
   - the Act works well and has improved the public safety through the introduction of a competency framework including mandatory reporting and setting core requirements for maintenance of competency throughout a health practitioner’s working life;
   - the Act is proving flexible enough to meet changing models of care delivery;
• nurses' awareness of their professional obligations to the public and competencies has increased;

• specific RA problems, for example gazetting narrow scopes of practice, should be addressed individually;

• there is potential to reduce costs by limiting the maximum size of an RA to 10, inclusive of two laypeople/consumer representatives;

• the potential for amalgamation of RAs regulating small numbers and where there is synergy, for example, with chiropractic, osteopathy and physiotherapy; or psychology and psychotherapy, could be further explored;

• nursing rejects a single RA because it would increase costs, risks medicalisation across disciplines, and would present an increased risk to public safety;

• RAs must be independent from political interference/influence;

• pastoral care is not an appropriate role for the regulator; and

• the HPCA Act is not the appropriate vehicle for addressing deficiencies in workforce planning, data collection, or resourcing.

DISCUSSION

20. NZNO rejects the rationale of assessing the operation of the Act against principles and "specific" foci focused on policy concerns such as "lower funding growths", the "need to move away from a focus on hospital services and admissions", "trade-offs" and "risk management efforts".

21. No evidence is presented that a review of the "policy principles underpinning the HPCA Act", which were extensively explored through wide consultation, debate and examination during the development of the Act, is warranted.

22. Further, we submit that the government statement on regulation Better Regulation Less Regulation with its emphasis on regulation that is "outdated, poorly conceived, poorly implemented" and "excessively costly" does not apply to the HPCA Act. The statement and the regulatory reform legislation are narrowly focused on facilitating business and profit; the HPCA Act is focused on making health care safe for New Zealanders, the cost being subsidiary to health outcomes. A health care business can be profitable without being good for consumers - the example of Milan Brych springs to mind. But in the long
term, good population health outcomes pay the best dividends (CSDH, 2008).

23. NZNO is confident that the Act is delivering a workforce that is responding safely and effectively to "transformational change", enjoys the public's trust, and is cost effective.

24. The RAs are responsible to the public and to the professions to ensure safe, high quality standards of health care, without being subject to external interference, for example, to lower/raise standards or change scopes of practice in response to the employment environment.

25. There is a very real distinction between an RA changing a scope of practice on the basis of evidence of safety and the availability of appropriate education and training, as opposed to change proceeding from, for example, exigent political or industrial demands, such as workforce shortages, funding shortfalls, or policy agendas.

26. An understanding of that distinction is not apparent in the document, but, whether deliberate or not, the indications are that there is a willingness to pursue the latter pathway, which would effectively subvert the independence of RAs, making them a tool of agencies responsible for health workforce planning and health care delivery, without the independent protection of standards.

27. While it is important to consider international trends and experience, NZNO is concerned that the New Zealand context - a small, bicultural, ethnically diverse, and geographically spread population, with a long tradition of a well educated health workforce and a publicly funded health system - has not been canvassed with regard to health workforce regulation and public expectations.

28. That context limits the number of roles that can be robustly supported with appropriate education, employment and regulation, and imposes expectations of equitable access to health care that may not be prioritised in the same way in other countries. Regulatory regimes are not transposable and the HPCA Act was developed by, and specifically for, Aotearoa.

29. We draw your attention to recent positive audits of both the Medical Council of New Zealand (MCNZ, 2010) and Nursing Council of New Zealand (NCNZ, 2012) by the United Kingdom Council for Healthcare Regulatory Excellence (CHR) which also endorsed Aotearoa New Zealand's regulatory system for health practitioners:

"We were impressed with many aspects of the approach to regulation that has been adopted in New Zealand. In particular, the philosophy of
attempting to deal with concerns about fitness to practise in a collaborative, non-adversarial way appears to work effectively in protecting the public in the majority of cases. There are aspects to this approach that could usefully be applied by regulators in other countries (MCNZ, 2010)."

Future Focus
30. We suggest that the future focus section conflates shifting professional boundaries with expanded scopes of practice.

31. Professional boundaries which underpin safe practice and professional conduct are not negotiable. Comprehensive guidelines advising health practitioners how to maintain appropriate professional relationships with health consumers and others have been developed by the RAs and are widely accessible.

32. Expanded scopes of practice to encompass new, demonstrated learning and skills, have been introduced in a number of professions - for example nursing, podiatry, and pharmacy - over the past few years and illustrate the flexibility of the HPCA Act in developing and establishing safe processes for implementing innovation.

33. The real issue, we suggest, is with blurred boundaries between unregulated health workers who do not have professional boundaries or scopes of practice, and regulated health practitioners who do.

34. Nurses report, and, anecdotally, the same appears to be true for the medical and allied health professions, that the safety, flexibility, and productivity of multidisciplinary teams is maximised by clear professional boundaries and scopes of practice where the role of each member of the team is well understood and each is accountable for his/her own practice: regulated health practitioners know what to do, don't get in each other's way, there is no confusion, or unwarranted assumptions/expectations.

35. That is not always true with unregulated workers whose role/job description may change depending on the employment situation. That is an unacknowledged risk, and is of increasing concern because of the, largely unmeasured, expansion of the unregulated health workforce, where job descriptions (and even training in the case of practice assistants) may overlap that of regulated workers - in this case, enrolled nurses.

36. The opportunities for confusion, misplaced expectations etc. abound. Nursing Council has risen to the challenge and has put in place direction and delegation of health care assistant guidelines for nurses, but the prospect of more unregulated roles, or the deregulation of some professions where the numbers are small, is sobering: it can only
increase the risk to public safety, and undermine robust, coherent health practitioner regulation.

37. There is abundant evidence that an appropriately trained and deployed professional workforce is cost effective and improves health outcomes, whilst the same cannot be said for the effectiveness of different skill mixes across other groups of health workers or the use of less qualified staff and “the associated issue of developing new roles remains relatively unexplored” (Buchan & Dal Poz, 2002; see also Blegen et al, 1998).

38. It is important to recognise that a flexible regulated workforce cannot and will not be the same as one where ‘flexibility’ gives licence for health workers to be used in any capacity according to the need of employers, for example, nurses working as midwives, or receptionists triaging patients. The former meets public expectations of safety and quality, the latter is open to the risk, exploitation and lack of public confidence which has prompted the robust health workforce regulation of the HPCA Act.

39. The risks associated with immigration are poorly canvassed. While we agree that it may be necessary to recruit and retain overseas practitioners (and indeed NZNO has undertaken research and made recommendations on this (Clendon & Walker, 2012)), we must do so only on the basis of evidence of need, and ensure that immigration is not used as a shortcut or alternative to developing clinical leadership and career pathways for practitioners.

40. The introduction of physicians' assistants (PAs), following a very poor demonstration and flawed evaluation (NZNO, 2012) is an outstanding example of overseas recruitment undermining the employment opportunities and development of the local workforce. To pay NZ $130,000 p.a. for unregulated, unsupported foreign workers when there are nurse practitioners and registered nurses with relevant scopes of practice available is “excessively costly” and unnecessary. There are no education programmes for PAs in New Zealand and there are cost, quality and logistical challenges to supporting clinical roles for very small numbers within the limited resources of our small country.

41. The future focus of a culturally competent health workforce should acknowledge the position of Māori as tangata whenua to meet equity obligations under te Tiriti o Waitangi, and include strategies that will lead to more proportionate ethnic representation in the health workforce.

Consumer focus
42. NZNO entirely rejects the concept that there should be a trade off between the safety of the public and access to services as implied by the statement “the cost society is willing to bear for the benefits of public safety and the trade-off between highly qualified and regulated health practitioners and improved access to services”.

Safety Focus

43. There is no evidence that all employers provide adequate safety mechanisms. It is unlikely that all employers will have the will or capacity to have the systems and structures in place to support competent practice; while larger organisations may achieve this, smaller ones may not.

44. In addition, the public has a right to expect a certain level of care from any regulated practitioner, regardless of whether they are receiving care from them in an employed capacity or outside a health care employment setting, for example, if attending to injured people at a road accident. If the care is provided outside of work hours, then employer standards are not applicable, but, under the HPCA Act, a practitioner is always accountable for his/her practice through the RA.

45. We note that the review invites comment on the wider legislative context of health and safety in the health and disability sector. It is therefore surprising that it does not mention the concurrent reviews underway which have the potential for significant impact on health and workforce regulation: the Standards and Conformance Infrastructure Review (Ministry of Business, Innovation and Employment) and the Independent Taskforce on Workplace Health and Safety’s comprehensive review of workplace health and safety.

46. There have been significant and far reaching legislative and policy changes over the past few years that have directly and indirectly negatively impacted on occupational health and safety and access to health services. In this dynamic and changing employment environment, the HPCA Act has guaranteed the standards of care given by competent, fit to practise health professionals.

47. Within the wider legislative context of health and safety, NZNO advises that, for nursing, the main concerns are:

- lack of long term health workforce planning;
- lack of capacity to manage and enforce appropriate levels of staffing to ensure consumer safety (North, 2012);
• continued high dependence on internationally qualified nurses (IQN) with immigration replacing workforce development (Zorn & Dumont, 2008);

• lack of recognition and education to address safety issues posed by the large and disparate internationally qualified health workforce (NZNO, 2011);

• changes to employment legislation which undermine good industrial relations that underpin cooperative and robust health and safety programmes;

• changes to ACC that reduce provisions for occupational safety and rehabilitation; and

• increasing recruitment of unregulated health workers without appropriate consideration of the effect on safety and professional boundaries.

48. There also needs to be legislative protection on the following:

• Selection of representatives on health and safety directly by workers (not those 'shoulder-tapped' by the management).

• Protection of health and safety representatives from victimisation or discrimination as a result of their representative role.

• Paid time off to be allowed to carry out the function of safety representative.

• Paid time off to be trained in order to function as a safety representative.

• The right to receive adequate information from the employer or principal on current and future hazards to the health and safety of workers at the workplace.

• The right to regularly (i.e. at least quarterly, but more frequently during periods of change) inspect the workplace during the representatives paid working time and when the operation is working (where safe and practical to do so).

• The right to investigate complaints from workers on health and safety matters in representatives paid time.

• The right to make representations to the employer or principal on these matters.
49. NZNO also recommends having ESR set up a division where health and safety representatives and government (ACC-based Labour Inspectors) can access the results of scientific testing and information. The current list of individual hazardous components is barely helpful in those cases where they are properly contained and labelled, but become irrelevant and potentially dangerous when mixed in combination with others, or as a result of contamination. The current safety limits based largely on US recommendations, are entirely inadequate and unsafe. Ammonia, for example, is listed as having an eight hour safety limit yet people have collapsed after being exposed to levels 25% below the ‘safe limit’ for only 10-15 minutes.

50. There are issues with health and safety legislation, but the HPCA Act is not one of them.

Cost Effectiveness

51. We note realistic concerns that under the HPCA Act, there is the potential for the unnecessary proliferation of RAs and narrow scopes of practice on the one hand, while on the other, the regulation of obvious candidates such as anaesthetic technicians and advanced paramedics has been demonstrably tardy.

52. The Act’s appropriately open provisions for the continuation and establishment of responsible authorities (Part 6, Section 116) i.e. where there is a risk of harm, and it is in the public interest, are clear. The
problem lies with the government's unwillingness to make consistent, timely decisions based on evidence, not the legislation. Delegating responsibility to employers and practitioners themselves, whose objectives, authority and resources are not the same as the mandate of government, risks both public safety and optimal use of the health workforce.

53. If nurses were to become ‘unregulated’, for example, there would be a huge reliance on a credentialing process. This would have significant costs for nurses and the profession and could be seen as a way of off-loading fiscal cost of regulation from the government to the individual. It could also affect recruitment for nursing as a profession given that the costs of qualification and subsequent credentialing would be prohibitive. The long-term consequences of removing regulation need to be carefully considered.

54. Employer credentialing is safe only within the context of national developed guidelines and standards, and robust, consistent health workforce regulation.

55. Under self-regulation the number of codes and programmes would undoubtedly proliferate, and what obligation/guarantee would there be to ensure the public was aware of differences in quality?

56. NZNO notes that the separation of the disciplinary process and establishment of the Health Practitioners Disciplinary Tribunal (HPDT) has increased cost for the RAs and yet they have no control over those costs. RAs are required to reimburse the HPDT for the cost of hearings.

57. However, the professional conduct committee (PCC) process acts as a filter for the Tribunal, and in this respect, keeps costs and waiting times down.

58. The rehabilitative role of the Health Committee is also valuable and maximises the retention of skilled practitioners.

59. We do take issue with Section 106 where the right of appeal does not include the right to appeal against a decision not to revoke a suspension of registration under Section 51(1) or a decision not to revoke conditions under Section 51(2). This should be amended to ensure health practitioners have the usual rights of appeal.

60. A note regarding the costs DHBs bear for continuing education requirements. Under the Multi Employer Collective Agreement, nurses are given time off for continuing education, but pay the costs themselves. In practice nurses often find it difficult to secure the time off because of lack of resourcing or staff available to cover their shifts.
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 do not see health practitioner regulation being a barrier to integrated, patient-centre care. There are barriers to integrated care but the Act is not one of them.

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 Act is demonstrably flexible enough to meet emerging professional workforce and health challenges, as evidenced by the introduction of expanded scopes of practice in a number of professions - for example nursing, podiatry, pharmacy – which have allowed for the safe implementation of demonstrated innovation.

As mentioned in the previous review of the HPCA Act, we would like to see some consideration given to facilitating dual scopes, such as, developing processes to enable a shared structure for fees and recognition of professional development programmes. For instance, one practitioner who is a registered nurse and a registered psychologist maintains both registrations at some cost. While she chooses to work as a clinical psychologist, she draws on her RN expertise on a daily basis.

In mental health, maternity and other areas of health, there are practitioners who may be more appropriately registered in a broader manner rather than as a particular practitioner in order to ensure that more crossovers of clinical skills can occur.

NOTE: Workforce ‘flexibility’ must be related to patient outcomes.

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 strong consultative framework of the HPCA Act requires the RAs’ active engagement and communication with and between other RAs, professional organisations, education providers, qualifications authorities, employers, the Health and Disability Commissioner, legal authorities, the government, and individual practitioners i.e. all those implicated in effecting appropriate education and training of practitioners throughout their careers. In this sense the HPCA Act provides a useful forum for facilitating health workforce education and training that is meaningful in many contexts – health outcomes, skills, employment, examinations, research, professional development etc.

The purpose of this (and other) question(s) is not clear; is there an intention to replace the HPCA Act’s focus on appropriate education and training for each profession with, for example, a ‘wider focus’ on generic health workforce education? It would be useful to know the “direction of travel” here.

See also the answer to 2 above.

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:

There is scope within the HPCA Act to share some regulation - core principles can be seen in all codes, though they are tailored to meet the needs of each profession. However, the Act itself has addressed standardisation across health professions, replacing the disparate legislation – the Nurses Act, the Hospitals Act etc. - which preceded it. There is no reason why diverse professions operating in diverse settings and interacting with consumers in very different ways, should share exactly the same codes.

There are different philosophical approaches between many professions e.g. medical versus social health in nursing, and codes and ethics are informed by the philosophy of the profession; mandating commonality would potentially limit the broad and differing perspectives that are needed in health to ensure the needs of all people are met.

We note that the potential for the Health Regulatory Authorities of New Zealand (HRANZ) to play a great role was identified during the last review of the HPCA Act.

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

☐ Yes

Comment:
Yes.
The competency review process is positive in keeping practitioners up to standard and allowing them to continue to practice with rehabilitative support.

6. Could/should RAs have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?
   - No
   - Comment:

   No. It would be contradictory to mandate pastoral care from the same body that has a disciplinary function. Professional organisations such as NZNO provide pastoral and professional support for their members; many employers also provide professional counselling services etc for employees under stress.
   An independent pastoral care agency serving all practitioners (and/or professionals) could be an alternative, though we suspect that funding would be an issue.

**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
   - Comment:

   Yes. The very small number of health practitioners undergoing disciplinary procedures as a percentage of the health workforce is testament to the fact that the HPCA Act is keeping the public safe.
   RAs provide appropriate, accessible and timely information to consumers.

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
   - Comment:
In general yes, though the complaints process as it relates to practitioners in hospitals and large practices is generally dependent on the information given by health providers – District Health Boards, Residential Aged Care Facilities, Primary Health Care Organisations, rather than RAs.

Any change would need to ensure the protection of individuals whose practice was under they are entitled to a fair process.

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

☐ Yes
☐ No
☐ Not sure

Comment:

We suggest that the more important issue is ensuring the right range of governance skills on the Board. “Laypeople” is a broad term which may be variously interpreted to cover any member of the public, non-clinical experts, or consumer/special interest representatives, for example. Boards need to comprise people with relevant governance skills, and perhaps there needs to be some clarification of the term laypeople.

We suggest that two out 10 members of the Board could fit into this category.

NZNO recommends, with respect to te Tiriti o Waitangi that at least one member of the board should represent Māori; the HPCA Act has not so far changed ethnic disparities in health workforce representation, and this requirement across all RAs would give some impetus and capability of addressing the workforce challenges inherent in entrenched health disparities.

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

☐ No

Comment:

We would not see that as a priority. There is nothing in the Act which precludes groups such as grey power or other consumer organisations communicating with RAs and vice versa.

It has the potential to be resource intense with little gain, and could expose individuals to unfair treatment if complaints are raised in a public forum.

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?
Comment:

In respect of the HPCA Act and its compass, yes. We do not think this review is an appropriate place to seek views on the broader regulatory environment governing public safety.

However, as indicated in the first part of this submission, we note that there are two concurrent reviews underway with the potential to impact on health and workforce regulation. The Standards and Conformance Infrastructure Review includes the New Zealand Health And Disability Services Standards NZS 8134 which covers infection control, restraint and sets the standards for all health facilities providing 24 hour care: it is the fundamental reference tool for providers and practitioners. Several other standards provide guidance for safe practice and the health sector, which also relies on authorities such as the Medicines and Medical Devices Standards, Environmental Risk Management, the National Radiation Laboratory, Food Standards Australia and New Zealand etc. Remarkably however, this business-focused Review is taking place over a very short period with virtually no input or even awareness from the health sector, though the implications for health consumers, workers and employers are fundamental and significant. (NZNO, 2012).

The second review conducted by the Independent Taskforce on Workplace Health and Safety's is a comprehensive review of workplace health and safety.

In addition there have been changes in ACC and employer legislation, which have affected health and safety and the services that can be accessed. Similarly NZNO is aware of some adverse consequences of targeting reduced waiting times in ED and first specialist appointments.

Amidst this dynamic, and sometimes very unsafe and insecure environment, the HPCA Act stands, protecting public safety by maintaining the standards of the regulated health workforce.

Note the recommendations for legislative protection of health and safety and the safety concerns for nursing previously listed in the introduction to this submission.

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

☑ No

Comment:
No. Employer based risk management would only be possible with some large employers, and NZNO’s experience is that there is considerable variation amongst employers as to their commitment to safety and capacity to implement robust systems. New Zealand has an undeniably poor record of workplace safety; several recent reviews (and ones dating back to the privatisation of aged care) have pointed out that care is compromised by overwork, skills and staffing shortages, and lack of appropriate clinical and management tools to ensure appropriate, timely care.

Investment in Care Capacity Demand Management, and other appropriate planning and assessment tools such as InteRAI would improve patient outcomes and reduce risk more effectively than employer risk management systems. We applaud the government’s recent decision to make InteRAI mandatory in aged care by 2014.

NZNO does not support a reduction in statutory regulation; we would like to see what regulation there is properly enforced. We note that the sector-agreed voluntary standards for Minimum Aged and Dementia Care for New Zealand Consumers have rarely been even half met and are not auditable because they are not mandatory.

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:

Amend the Medicines Act and remove legislative contracting and funding barriers to nurse practitioners and other health professionals which prevent them utilising the full extent of their scope.

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
Comment:

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

Comment:

**Practising in professional isolation** may better define the risks described than sole practice which covers a number of situations, including practising alone, which, for a number of professions and practice areas, is normal and for which good risk management systems are in place.

In aged care for instance a single RN may be with and responsible for 65 residents, several ENs or health care assistants, but in terms of practice s/he may be isolated.

On the other hand a rural nurse specialist who will be practising alone, may, and indeed generally does, establish systems for regular professional supervision through relationships developed with GPs, PHOs and DHBs etc., and manages risks very well.

RAs have mechanisms linked to the APC that could be strengthened, professional organisations, online communication and education, better resourcing of funded professional development opportunities are all mechanisms which might lessen professional isolation.

The NCNZ competency framework includes "Reflects upon, and evaluates with peers and experienced nurses, the effectiveness of nursing care. (competency 2.8)"

Various codes and standards govern nursing practice.

Technology facilitates peer review and debriefing.

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?

□ No

Comment:
No. There are issues with defining high risk categories of practitioner; the HPCA Act is the risk management tool for the regulated health professions.

Cost effectiveness focus

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

Comment:

RA decisions impact directly on health practitioners through the cost of registration and annual practising certificates, some of which are paid by employers as part of the conditions of collective agreements or contracts. RAs are thus very aware of the cost implications of their decisions, as well as their statutory obligations and act responsibly as indicated by the UK, CHRE audits.

If amalgamation of the RAs proceeds, nurses fees and costs will go up. This will have cost implications for employers, such as DHBs who pay annual practising certificate (APC) fees. We suggest costs could be reduced by extending the APC to cover three years registration for an experienced practitioner where there has been no change of employment or disciplinary investigation.

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

☐ No

Comment:

No; it is not necessary to place arbitrary limits on the meaning of harm and serious harm.

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

☐ Yes

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
   - Not sure
   Comment:
   There are some anomalies such as Advanced Paramedics not being regulated when their practice clearly falls within the HPCA Act. We recommend progressing regulation of advanced paramedics.

21. Could the way RAs administer their functions be improved?
   - Yes
   - No
   - Not sure
   - Not sure
   Comment:
   With 16 RA it is likely that some may be able to improve the way they operate, but from a nursing perspective, we are satisfied that Nursing Council is efficient.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   - No
   - Not sure
   - Comment:
No. Present requirements seem sufficient judging from regular and appropriate consultation requests from Nursing Council and other RAs.
On the other hand we note the introduction of unregulated roles e.g. practice assistant, physician assistant, various mental health roles and health care assistants, where the education and qualification level overlap that of regulated practitioners, where there has been little or no consultation!
There is an urgent need for the reinstatement and adherence to the State Sector Guidelines for Consultation.

23. Should the number of regulatory boards be reduced, as in the UK?
   □ Yes
   □ No
   □ Not sure
   Comment: No unless the RAs/Professions clearly identified advantages to doing so and the autonomy of the professions involved was not compromised or lost. There may be potential for amalgamation of RAs regulating small numbers and where there is with synergy, for example, chiropractic, osteopathy and physiotherapy; or psychology and psychotherapy, and these could be further explored.

24. What is the ideal size of RA boards?
   Comment: This may vary, but we suggest that the maximum size of an RA could be limited to 10 members, including two laypersons.

25. Are there other issues you would like to raise?
   Comment:
We recommend progressing the regulation of advanced paramedics.

Please note the whole of our submission; we could not visibly fit* all our comments in this format, which is why we have used our own.

*the boxes expand only so much, after which, although the content is there, it is not visible, making it difficult for our staff and members to amend or make comments.

REFERENCES


http://www.nzno.org.nz/LinkClick.aspx?fileticket=jamaiLG7aWk%3d&tabid=179


APPENDIX 1

Proposal for a shared secretariat and office function for all health-related regulatory (sic) authorities together with a reduction in the number of regulatory authority board members, Health Workforce New Zealand (HWNZ) discussion document

In March 2012 NZNO sent an official information act request to HWNZ for:

- information and papers substantiating the claim that a savings of $11m could be expected from consolidating the back-office functions of the RAs and up to $13m for consolidating all 16 RAs into one organisation as per the discussion document; and
- the submission analysis showing the extent of sector support for the amalgamation of RAs

to see whether there was widespread sector support for the proposal as claimed, and whether the $11m savings was based on a more robust financial analysis than that in the proposal.

As a result of the OIA, it was clear that no further financial analysis had been undertaken and that no submitter supported the proposal for a single secretariat. The financial analysis was widely challenged as substandard - inaccurate, incomplete, out-of-date and not transparent leading to the conclusion that "It was considered unlikely that the estimated cost savings of $11.2m could be achieved." Projected savings, if any, were anticipated to be negligible compared with the perceived increased risk of harm to the public.

Professional and operational issues dominated the submissions. The document did not take into account the serious ramifications of the proposal - the potential for significant cost blow outs and undermining of a safe, internationally aligned regulatory framework for the health workforce - and assumed a very limited role and function for the RAs. A number of risks were listed - loss of expertise, increased fees etc. - as well as more viable alternatives focused on reducing costs through improved registration processes and increasing the APC period, which would be likely to be impeded by restructuring secretariats.

Though submitters acknowledged potential for cost efficiencies and operational synergies, a single secretariat (for which there was no support) was not deemed the most cost effective or operationally viable model. Nor was there much support for two "most favoured" alternative models: clustering of RAs with each group sharing a secretariat and the devolution of function to a single secretariat.
NZNO remains seriously concerned that the unanimous advice of experts who understand the business of regulation and those who work within the existing framework has been misrepresented and largely ignored. It seems inevitable that the proposal is proceeding without major modification and/or further consultation, that viable alternatives are being ignored, and that projected savings of $11m or sector support are treated as credible.
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: Sandra Richardson
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Email: Sandra.richardson@cdhb.govt.nz

Organisation (if applicable): Senior Nursing Team, Emergency Dept, Christchurch Hospital

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:

There do not appear any specific issues at present, it is important to maintain scopes of practice rather than blur all boundaries – there is insufficient evidence to date to suggest that a legislative change would be either appropriate or effective if the intention was to make a more responsive workforce. The existing system appears to be working effectively, no clear need to alter this. There is also limited information provided about the processes of integrated care and how these might benefit from changes to the current system – additional evidence and acknowledgment of the barriers associated with an integrated care model would be appropriate.

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 system as it stands appears to be sufficiently responsive and flexible – there have been changes to existing scopes and processes that indicate the system is responsive to changing workforce needs, while still maintaining professional boundaries. While there is clearly a need for multidisciplinary and integrated service provision, and there are some generic aspects to health care, the individual professions still offer something unique to each which risks being lost if a single, homogenous and non specific approach is taken to healthcare registration

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:
The current professional codes of conduct and ethics appear to be working effectively at present, there is no clear need for change identified at this stage. There is no suggestion that the current variation presents confusion or risk to public safety.

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:
While current scopes of practice descriptors vary between professions, there appears to be sufficient information and detail to allow both lay people and other colleagues to identify the role and expected competencies of a registered health professional. What is much less clear is the role and expectations associated with the increasing numbers of unregulated health and disability workforce personnel.
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 is currently (and should remain) outside the scope of the RAs. Introducing pastoral care requirements has the potential to blur the role of the RAs, introducing a conflict of priorities and causing potential risk when the RA is faced with managing disciplinary issues at the same time as pastoral care support. The current disciplinary tribunal allows for support of health professionals from other agencies, eg professional bodies, employers etc and this is where the focus should remain.

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:

By working in concert with the other relevant pieces of legislation, and in particular with the Health and Disability Commissioners office and the implementation of the Code of Rights the existing systems seems to be working effectively to maintain public safety and disseminate information.

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 existing system is sufficiently transparent. It would not be appropriate for full disclosure of content of complaints, especially when these may be unproven. An understanding of the process is important, and this information is freely available, but there must also be a balance and protection of the health practitioner’s privacy rights.
9. Do we have the right balance of laypeople to health professionals on RA boards?
   x Yes
   □ No
   □ Not sure
   Comment:
   The overall balance between lay people / consumer representatives and health practitioners is appropriate. However, what is of concern is that currently many of these are political appointments, and as such there is always the potential (or appearance of potential) for political agendas to be reinforced through selection and appointment as part of a political process.

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
    x No
    □ Not sure
    Comment:
    There is no clear evidence presented to suggest the need to move towards this model, and the likely costs are not shown to reflect actual benefit to the process. There is the potential for these to be used as part of targeted agendas, either against individuals, professional groups or health care processes. It is unclear that this would contribute significantly to public safety. Improved communication between consumers and providers is probably more of relevance, rather than at the generic health professional level.

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:
    There is a balance of legislative requirements that are currently applied within the health and disability sector and which work together to support public safety.
12. Can we make better use of other legislation or employer-based risk management systems and reduce reliance on statutory regulation?

☐ Yes
☒ No
☐ Not sure

Comment:

There is always the potential to use the existing processes in a more effective and efficient way, but this would not equate to the need to reduce statutory regulation. In particular, the consideration of employer regulation is fraught with ethical and practical concerns. There is a clear potential conflict of interest between the employer and employee and also between the employer and the public. The underlying goals are not necessarily aligned, and there is the opportunity for increased conflict, introduction of fiscal, political or management agendas that do not necessarily support either public safety or professional development.

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 are areas of potential overlap, but no evidence that this is sufficient to result in redundancy of effort.

Consideration needs to be given to the restrictions imposed on practitioners by the current ACC regulations and the definitions of approved providers.

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 acknowledgment of risk seems appropriate and specific to the range of professions represented – the risk of developing a generic risk statement is that it becomes so broad as to be meaningless in terms of implementation.

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

Comment:

These risks seem to be managed appropriately at present through attainment of professional competencies, and in particular competency based practice certificates. Other resources include interaction with professional organisations.

The suggestion that employee ‘vetting’ provides certainty or safety is subject to dispute, with a number of high profile cases suggesting this is not the case.

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 existing processes appear to be sufficient in identifying risk associated with currently regulated professions, however there are a number of unregulated health care workers where this would be a useful process (but they lack a RA)

Cost effectiveness focus

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

Comment:
Given the focus on patient safety, there needs to be recognition that cost benefit analysis is a secondary element. While all organisations need to consider this as part of their operational processes, it should not be seen as the priority or driving factor.

18. Should the HPCA Act define harm or serious harm?
   - Yes
   - No
   - Not sure
   Comment:
   There is sufficient definition available in terms of legal statutes.

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:
   Again, no evidence to suggest this is problematic has been identified.

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 existing regulatory frameworks is effectively managing risk, but there is a need to expand this to consider the currently unregulated workers who have the potential to impact on public safety.

21. Could the way RAs administer their functions be improved?
   x Yes
   □ No
   □ Not sure
   Comment:
   Improved secretariat support, as is currently being scoped.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   □ Yes
   x No
   □ Not sure
   Comment:
   Existing consultation is sufficient

23. Should the number of regulatory boards be reduced, as in the UK?
   □ Yes
   x No
   □ Not sure
   Comment:
Changes to representation should not be driven solely by the number of existing boards. There may be opportunities for some similar areas to combine and work together, especially those with small numbers and/or similarity in practitioners or health population, but this is a separate process.

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

There is the potential to reduce the size of RAs to 10 (from the current maximum of 12), including 2 consumer representatives.

25. Are there other issues you would like to raise?
Comment:
There is no clear deficit in regard to the current system that has been identified and which needs to be addressed.

The existing system appears to be working effectively, and as such there is no mandate to introduce legislative change.

There is no evidence to suggest a single RA to oversee health practitioners would be beneficial.

There has been very limited inclusion of the role of currently unregulated health and disability workforce staff, yet this is of concern to both public and health professionals alike.

The overall structure of the feedback template suggests existing (and limited) agendas and areas of focus, and by providing such specific direction risks introducing bias in relation to issues that may not have been spontaneously identified without this.

There is a lack of evidential base underpinning many of the suggestions and directions identified within the review document, and no referencing in the document itself (limited inclusion of references in the appendices, and these are presenting only certain perspectives). Lack of credibility without consideration of the range of evidence available. While there are certainly advantages to the integrative health care model, there are also documented disadvantages / barriers to its introduction. Similarly there are a number of assumptions and generalisations that need further evidence, support and clarification.

It is not clear why there needs to be a ‘trade off’ between having highly qualified and regulated health practitioners and improved access to care (p10) – many of these qualified and regulated practitioners have also introduced innovative and responsive service approaches that allow for improved access to care (eg nurse led clinics)

The comparisons to changes being made in Australia, UK and Canada are not placed within context – ie the very different health care systems and in particular health care funding models. It is not always appropriate to utilise international models in NZ.

Role of ACC in limiting practitioner scope of practice not identified in the discussion document, and the suggestion that this legislation “avoids the need for professions to protect themselves at the expense of public accountability” is dubious at best. Again, evidence to support / clarify this statement is needed.

There is an assumption (p14) that a competitive / commercial model is best for health care regulation, ensuring there is no ‘unnecessary restriction’ on people’s ability to work. There is a risk that the fiscal/commercial role becomes a more significant factor, with the potential to minimise professional input into safe practice standards, as identified by the professional experts.

The suggestion is made that health practitioners are “limited by their scopes of practice and their self assessment of their level of competence” (p18), however competency based practicing certificates involve a wider range of evidence and peer review.
Submission in Response to the Ministry of Health
Review of the Health Practitioners Competence Assurance Act
2003

Prepared
by the

New Zealand Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

26 October 2012
The New Zealand Psychological Society is the premier association for professional psychologists in New Zealand. It is the largest professional association for psychologists in Aotearoa/New Zealand with over one thousand practitioner, academic and student members. Our vision is “To improve individual and community wellbeing by representing, promoting, and advancing psychology and psychological practice”. We have chosen in this submission to emphasise the issues of most concern to our members rather than respond to each of the 25 questions in the consultation documents.
Introduction

1) We express our general satisfaction with the work and functioning of the Psychologists Board and the collegial relationship which has evolved with practitioners, including the members of the NZ Psychological Society. The Psychologists Board has for example been very accommodating in adapting its Continuing Competence Program (CCP) to include a variety of examples which better reflect the variety and breadth of work undertaken by psychologists.

2) The 2009 review of the HPCA Act resulted in 37 recommendations, the first being that there would be a further review in 2012. We are dismayed that the omission of any reference to bicultural issues in the 2009 review has been repeated; the word ‘Maori” simply doesn’t appear in the 2012 consultation documents. We are satisfied that our Responsible Authority the Psychologists Board has enacted in part or in whole the recommendations (2, 3, 5, 6, 7, 8) relating to its activities but we share with it concerns about the amalgamation (recommendation 18) of two or more existing authorities and the recent proposals for creating a single secretariat. Recommendations 18 to 29, 32 to 34 and 36 and 37 are still awaiting legislative amendment.

Consumer Focus

3) The HPCA Act whilst generally serving well its function of protecting the public has created a number of anomalies for practising psychologists. That psychologists who are not registered within the clinical scope (or work as health psychologists, neuropsychologists or in the disability sector) do not have access to the Ministry of Health Ethics Committees is the most significant of these. This is of particular significance for the NZ Psychological Society because approximately 50% of its 1000 members do not fall within this scope of practice but may wish to be involved in research involving human participants who are not consumers of health or disability services. Psychologists in the educational scope of practice or counselling psychologists for example, may need to conduct research on psychologically vulnerable child populations who do not fall within the ambit of HDEC. Unless they are University staff members or students and therefore have access to a university ethics committees or work within a health service, they will not have access to an ethics committee in order to get ethical approval for such research. They thus face a double jeopardy of offering psychological interventions which do not have the required research and evidence base or of conducting research in order to provide the evidential basis for their work, without first obtaining ethical approval. The enabling legislation for the HDEC ethics committees is the Health and Disabilities Services Act 1998 and s7 and this may therefore need to be amended.

4) Another significant problem is the way the HPCA Act deprives academics whose disciplinary base is psychology, the right to call themselves psychologists. Our membership includes many academics who fall into this category. We recognise the value of disciplinary research from which provides the evidence base for our practice
and strongly support the rights of academics working in psychological fields the right to call themselves psychologists. We recognise however that they would not see themselves as health practitioners and would not want to register in any scope of practice. We are mindful that the Heads of Schools and Departments of Psychology at NZ Universities have addressed their submission on this second issue and we are fully supportive of it. This anomaly creates an unnecessary and for the public a dangerous separation between practitioners and their research bases. It also has the potential to undermine the coherence and robustness of the discipline that informs our work.

Future Focus

5) The distinguishing features of psychiatry, psychotherapy, counselling and the many areas of psychology seem to have been missed or ignored in the original drafting of the HPCA Act. We acknowledge that the drafting and passing of any significant piece of legislation is likely to result in the creation of quite a few anomalies, distortions and ‘unintended consequences’. We note for example that recommendation 2 of the 2009 review required Responsible Authorities to “do more to inform the public about the Health Practitioners Competence Assurance Act ... including making business information about registered practitioners freely available”. It is difficult to do that when the defining legislation fails to make critical distinctions between the different and often distinct forms of psychological practice. We believe that it would be timely to correct these misunderstandings and omissions within the current review, for example by expanding the number of scopes of practice to at least include the major occupational groups and workplace settings.

6) An additional and related issue for the NZ Psychological Society is the variety in psychological practices of its membership, many of whom probably to their surprise were deemed to be ‘Health Practitioners’ when the Act was first passed. The ‘medical model’ has dominated in discussions about the HPCA Act, Health Work Force New Zealand and the Responsible Authorities. A problem in unquestioningly implicitly accepting a single model (which we acknowledge is entirely appropriate in considering physical health, mental health, neuropsychology and disability issues), is that it does not accurately reflect the contribution that psychologists from other traditions can and do contribute to social current problems that impact on health and wellbeing, for example in education and criminology. Many psychological practitioners (e.g. applied behaviour analysts, community psychologists, coaching psychologists, sports psychologists and many educational and developmental psychologists) in fact work primarily within humanistic, behavioural, developmental, ecological or systemic models of professional practice. Industrial / organisational psychologists provide another example and we note that quite a few have either vacated or simply not sought registration but have continued to work in the same capacity in for example, human resource departments.
Safety Focus and Cost Effectiveness Focus

7) Another general concern relates to the moving or blending of professional specialties and boundaries through changes in the political processes and funding mechanisms. We are aware that HWNZ is keen for psychosocial interventions and services (and of course other health and disability services) to be more accessible to the public. In many District Health Boards for example non-psychologist health practitioners (e.g. nurses) have been given basic training in cognitive behavioural therapy (CBT). This entails a deliberative blurring of the boundaries between the different professions and between the scopes within each profession and may contravene some of the purposes of the HPCA Act if not closely monitored. In the same vein the recent discussions with HWNZ about psychologists being trained and given pharmacological prescribing rights raises reciprocal and similar issues. We believe that as a condition of registration, all health practitioners should belong to a professional association that is relevant to the kinds of services that they provide.

8) In respect of the point above, although we appreciate that a balance must be struck between availability, costs and the maintenance of professional standards, there is a risk to the public by services being offered by less well-qualified health practitioners. We wonder for example how a Responsible Authority might handle a professional practice complaint about one of its registrants in a domain or scope that more properly belongs to another Responsible Authority. We think that the public is best protected when clear professional boundaries between each health practitioner group are maintained and suggest that there is a need for each to retain a discipline-specific code of ethics in addition to the core Code of Health and Disability Service Consumer’s Rights 1996. We also wonder with the advent of Internet-based therapies and consultations, how complaints about practitioners operating across different legal jurisdictions will be handled.
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: Ravi Vas Vohora

Address: Post Box 12022, Maori Hill Post Centre

(town/city) Dunedin 9043

Email: vohora@xtra.co.nz

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)

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

☐ Other (please specify): Health Professional (unregulated)

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

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

☐ Yes

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

☐ I do not have any objection to release of my personal details
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 HPCA Act should remain specific to competence assurance matters.
I have good reasons to believe it would be desirable to have separate legislation confined specifically to effectiveness and efficiency of healthcare services provision and delivery. This could include integrated care matters.
I would propose a title for such legislation, namely, Healthcare Workforce Efficiency Act.

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 HPCA Act has provision for designation of new and additional professions.
There are good reasons to believe (informed by economic, management, organizational, sociological, and other theories) and I hold the view that ‘inflexibility’ in the health workforce is the consequence of or is related to ‘path dependency’ in the healthcare sector.
Path Dependency can be addressed by the designation of new and additional professions (with corresponding unique scope/s of practice/s)
I shall be publishing a paper on this topic. A copy would be available to any interested parties including to your and other units of the Ministry of Health.

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 sure

Comment:
Please see my response to question 1 above.
Keep the HPCA Act for competence assurance matters and have other legislation for other matters.

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:
All discourse on the topic of ethical conduct can be related back to the Melian Dialogue (from the Peloponnesian War, the long and interminable war between Sparta and Athens, 431 to 404 BC). The Melian Dialogue underpins the notion of ethics. There need not be any impediment to standardisation of ethical codes. Any undue departure in any professional code from the foundations of ethical conduct outlined in the Melian Dialogue should be viewed with scepticism and caution and the code rejected if necessary. The professions are not above unethical conduct and hence the need for codes of ethics. All the more reason these codes remain focussed on ethics and do not become a ruse for other agendas. The division of labour in society extends to knowledge. Specialised knowledge like other forms of specialised activity will continue to provide benefits to society which should not be foregone. For this reason, common learning across the professions should remain confined to the pre-professional stage of education and training. Otherwise economies of specialisation may be lost.

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:
Different professions need broader or narrower scopes of practice. The scope for flexibility should be maintained. It is important that all scopes of practice are and remain lucid to any interested well-educated layperson in New Zealand.
6. Could/should RAs have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?

☐ Not sure

Comment:

Instead of RAs, professional associations and colleges and perhaps other relevant institutions should assume responsibility for pastoral care. The RAs should have the discretion to direct a practitioner to seek and obtain appropriate and specific pastoral care when relevant.

Consumer focus

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

☐ Not sure

Comment:

My personal experience does not impart much confidence. The problem may be confined to the one RA I had encounter with (the Pharmacy Council).

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?

☐ Not sure

Comment:

There is no reason to believe that the RAs are above legerdemain. Hence the rhetorical question from the mists of time, namely, “and who shall guard us from the guardians?”.

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

☐ Not sure

Comment:
There may be advantage in having equal numbers of professionals and laypersons (where the laypersons always are well educated persons including from other professions).

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

Comment:

It is important that public members do not feel ‘powerless’ in their communication with RAs.
I am aware of public members being ‘fobbed-off’ by at least one RA (the Pharmacy Council).

**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

Comment:

The problem is not inadequate legislation or enforcement of legislation but the ‘states of mind and attitudes’ of providers which can lead to safety problems.

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

☐ Yes

Comment:

The primary focus should be on legal principles relating to ‘duty of care’ to patients. The notion of ‘duty of care’ includes the duty to maintain competence, avoid undue risk, etc.
These legal principles can, should, and often are embodied in systems developed to mitigate and manage risk and in other legislation.
See also my answers to questions 1 and 2.
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:

See my answers to questions 1, 2, 12 and 14.

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
Comment:

There exists provision for enactment of regulations under the HPCA Act. Any such regulations would provide all the necessary scope for ‘fine-tuning’.

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

Professional associations or the Ministry of Health should provide training and issue guidelines.
I believe that may already be the case.

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
Comment:

It goes without saying that would have to be in place suitable caveats to ensure that the RA did not ‘get it wrong’.
There is a need for constant vigilance with respect to “who shall guard us from the guardians”.

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 not aware that RAs have played any useful role in this respect.

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

☐ Yes

Comment:

Enactment of Regulations could help. See my answer 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?

☐ No

Comment:
20. Is the right set of regulatory options being applied to manage the risk of harm to the public that different health professions might pose?
   □ No
   Comment:
   See my answer to question 14.

21. Could the way RAs administer their functions be improved?
   □ Yes
   Comment:
   The RAs should seek to remain answerable for their decisions and actions.
   It seems to me that at least one RA, namely, the Pharmacy Council, in my case and in at least one more case that I am aware of, has failed to act properly. I am able and willing to support the assertion I have made by relevant evidence.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   □ Yes
   Comment:
   The consultation should not be limited to the (often mainly self-appointed) representatives of a profession or to special interests within that profession. There is need for specific provisions and safeguards for persons who become a ‘lone voice’ or a ‘voice in the wilderness’ by not succumbing to ‘group-think’. I limit my above comments to the Pharmacy Council. I do not have familiarity with the mode of operation of other RAs.
23. Should the number of regulatory boards be reduced, as in the UK?
   □ Yes
   Comment:
   See my answer to question 2.
   While I favour designation of new and additional professions to add flexibility
   and to overcome ‘path dependency’, I believe this need not be accompanied by
   additional RAs.
   There exists scope to reduce the number of RAs.

24. What is the ideal size of RA boards?
   Comment:
   Generally speaking groups of between 5 to 9 members have been shown to be
   optimal when it comes to size of boards.
   The above finding was with respect to business and management.
   I do believe that the finding possibly would apply more generally.

25. Are there other issues you would like to raise?
   Comment: Yes. See comment in box below.
See my answer to question 2.
The creation of additional professions could address many issues.
My own interest is in
  • the utilization of professional training of pharmacists
  • mitigation of Baumol cost-effects (also known as the Baumol cost disease) in health systems.
I would be happy to provide further information and assist in the process of the review of the HPCA Act.
It would be helpful that the review process should recognize that many learned persons are for various reasons not members of an established professional organization. I am an example. I am no longer a member of a recognized profession regulated by a RA under the HPCA Act. I can however still help.
My submission should be regarded as different from that of an individual professional or of an individual layperson.

Ravi Vas Vohora, BSc Pharm Honours (Strathclyde), MRPharmS, MRSNZ.

Telephone 03 4667680.
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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)

Address: (street/box number)

(town/city)

Email:

Organisation (if applicable):

Position (if applicable): Podiatrist

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): ...............................................................

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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/ Scopes of practice could be described in broad terms so as not to be overly restrictive, allowing

a/ professions to develop skills in response to changing contexts.
b/ reducing the possibility of a service gap, for consumers, between “integrated” service providers or professions.

2/ I imagine to improve integrated care the HPCAA Act would need to either include, or interact, in some way the various business/service models that exist in the public and NGO sectors. Which I guess also becomes about funding and current policy.

3/ I suspect that improving integrated care would be beyond the scope of the HPCAA Act, it’s my observation that integration and service delivery is primarily driven by the financial component unless a clinical/health issue is seen as significant enough to demand change. Currently I don’t think the HPCAA Act has the scope to impact on service funding contracts and the service delivery plans of various providers

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

Comment:
Scopes of practice could be described in broad terms so as not to be overly restrictive, allowing
a/ professions to develop skills in response to changing contexts.
b/ reducing the possibility of a service gap, for consumers requiring multidisciplinary care, between some professions.

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:

1/ Is this a realistic goal for the Act?
2/ possibly by directing RA’s to include these in Continuing Professional Development Activities
3/ or by finding a way to influence undergraduate courses to include it

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:

1/ is there evidence that this is necessary?
2/ Are professions too different to be able to standardise these aspects?
Ideally if it could be achieved, in even a limited form, I think the act should attempt to address this.

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/ I’m happy with my own profession’s description of scope of practice
2/ As a consumer I rely on “general knowledge” and personal experience, rather than looking up scopes of practice to develop an expectation of a health professional. I don’t know what other people do.

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:

1/ While the current Act focuses on public safety, the role of the RA’s also impacts directly on the professional groups e.g. prescribing CPD programs, resolving disciplinary issues, numbers in the workforce. Given this I think the RA’s have a responsibility to consider the effect of their decisions on professions and this could include a degree of “pastoral care”

2/ This could be carried out by providing support to CPD that was inclusive of both public and private sector professionals. Some small professional groups have members that work in rural areas, or just small numbers. An expansion of the type of support that has been available in Northland, for around 10 years, with the Northern Rural Nursing and Allied Health Professionals Consortium, may be a model worth expanding. I do feel professional groups outside of Medical Practitioners and Nurses, employed within Public Hospitals, do not benefit from the same support offered for CPD within the Hospital environment.

I imagine this would also require more funding from somewhere.

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/ Are there statistics to support that the public has been kept “safe”? or informed? Perhaps a poll of the public would be more informative, than response to this consultation, in assessing this.

2/ I do think having laypeople on the RA,s is a useful step.

3/ Possibly it depends on individual RA’s as to how involved the public is in decision making.

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/ I can’t speak for the public, how could we tell if they make good use of RA information?

2/ I think RA information is readily available if you can access the internet websites

3/ I think it would be useful to professionals if details of complaints and outcomes were published ( less names/identifying details) to inform professionals and add to “reflective practice”

4/ I don’t think there is adequate transparency around complaints

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

☐ Yes
☐ No
☒ Not sure

Comment:

1/ If there are more professionals on the RA than laypeople I could imagine at times that the imbalance could create a situation where the RA was serving the interests of the profession. Possible an equal number would be appropriate.

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
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:

1/ I think lay people are more likely to be useful rather than consumer groups who I suspect could have their own agendas to promote.

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:

1/ How could we tell if “we” made the “best” use of the current legislation?

1/ I think employer-based risk management systems would disadvantage small professional groups and those who are sole/self employed practitioners
2/ I think there would be a risk of fragmenting “risk management” and creating a variance of quality that would increase risk to the public. Also this may be a barrier to the public who are trying to select a “safe” provider.
3/ The employer may have a conflict of interest that compromises risk management. Having an outside party regulate this reduces that possibility.

13. What more needs to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?
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
   - [x] Not sure

Comment:

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

Comment:

   1/ Equitable access to CPD programs and Audit tools
   2/ Possible RA’s could support some sort of “peer review/support” initiative

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:

1/ I wouldn't be in favour of this, I think it promotes a sense of anxiety. Presumably there would have to be a system for “risk screening”. Sounds costly and unhelpful.
2/ I think it would be more constructive to provide something else that was supportive to all members of the professions to assist them in their roles.

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/ I don’t know, current legislation doesn’t seem to hold them too it. I do think RA’s should consider the full implications of there decisions

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
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:

1. It seems reasonable to consider “risk of harm” as a spectrum around particular activities rather than specific to individual professions.

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:
1/ I suspect this would come at a cost

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:
1/ members of RA's should have a standard of training in “Governance” (I presume they probably have some training) and this should be consistent across the RA's

2/ I think it would be better to follow a model similar to Australia or the UK where a national body supports individual boards.
NEW ZEALAND COUNCIL OF TRADE UNIONS
Te Kauae Kaimahi

by

New Zealand Council of Trade Unions
Te Kauae Kaimahi

Submission on

2012 Review of the Health Practitioners Competence Assurance Act 2003

26 October 2012
Summary of NZCTU Recommendations:
The Health Practitioners Competence Assurance Act 1993 (HPCA Act) is fit for purpose and provides much of the necessary solutions to address potential problems which may affect the effectiveness of the HPCA Act. We do not believe major changes are required to the scope, functions or operation of the HPCA Act.

The intention of the HPCA Act review or what it is seeking to achieve is unclear. There is in insufficient information and analysis to support the issues stated in the review document. We encourage further consideration of evidence, analysis of problems and available options, and likely impacts.

Potential changes to the HPCA Act must ensure safety, competency and care to the public are not adversely affected in pursuit of efficiencies and cost savings.

We encourage consideration of the review outcomes from the Standards and Conformance Infrastructure review conducted by the Ministry of Business, Innovation, and Employment (MBIE) which may have an impact on the review of the HPCA Act and the Independent Taskforce on Workplace Health and Safety’s review of workplace health and safety.

Given the complexities, autonomous role and accountability measures of Regulatory Authorities we urge due consideration of issues before any decisions are finalised regarding the amalgamation of a shared secretariat.

Workforce data collection and planning is the role of groups such as Health Workforce New Zealand. They have been specifically tasked with the role of workforce planning of which workforce data collection is and should be a prerequisite.

We consider the HPCA Act is already operating in a flexible manner but have concerns in respect of the interface between the regulated and non-regulated workforce and potential issues that may arise between professional boundaries and scopes of practice for practitioner groups.

We support greater transparency of information and processes however we encourage due consideration of privacy issues in regards to transparency of information.

Consumer representation is not an issue for the HPCA Act as there are other available avenues in which good consumer representation can either be enhanced, achieved or democratically recognised.

We consider the HPCA Act is sufficiently clear on the level of risk assessment.

The CTU supports the inclusion of additional professional groups that may wish to come under the HPCA Act but we believe there should be strong mechanisms including robust criteria for inclusion.
1. **Introduction**

1.1 The New Zealand Council of Trade Unions - Te Kauae Kaimahi (CTU) is the internationally recognised trade union body in New Zealand. The CTU represents 39 affiliated unions with a membership of over 350,000 workers.

1.2 The CTU acknowledges Te Tiriti o Waitangi as the founding document of Aotearoa New Zealand and formally acknowledges this through Te Rūnanga o Ngā Kaimahi Māori o Aotearoa (Te Rūnanga) the Māori arm of Te Kauae Kaimahi (CTU) which represents approximately 60,000 Māori workers.

1.3 The CTU welcomes the opportunity to make a submission on the Review of the Health Practitioners Competence Assurance Act (HPCA Act) 2003. The CTU supports the submissions of CTU affiliated health sector unions.

1.4 The CTU has an Active role in health sector forums including the Health Sector Relationship Agreement (HSRA) and the National Bi-Partite Action Group (NBAG).

1.5 It has been indicated that the review of the HPCA Act is just that – *only a review*, therefore it is difficult to understand why there is much urgency around consultation. The short public consultation process makes it difficult to provide well informed and considered submissions on what can be very complex and far reaching matters. These concerns are reflective of affiliated health sector unions, networks and members of the public.

1.6 The CTU notes the aim of the HPCA Act is to protect the health and safety of members of the public from harm and provides a mechanism for ensuring health practitioners are competent and fit to practice in their professions. The CTU supports these aims and submits that if there are any changes to the HPCA Act, these must ensure safety, competency and care to the public are not adversely affected in pursuit of efficiencies and cost savings.

1.7 We believe there may also be potential overlaps between the HPCA Act review and that of the recent Standards and Conformance Infrastructure Review (including health care standards) conducted by MBIE. The consultation process is now complete for the MBIE review but of which outcomes may have a potential impact on the HPCA Act. We understand that there was little input from the health sector into this review.

1.8 We also note the Independent Taskforce on Workplace Health and Safety’s review of workplace health and safety and the potential impact outcomes may have on the HPCA Act review.
1.9 The consultation document asks a number of questions in respect to the HPCA Act. As some of these issues fall outside the ambit the CTU, this submission focuses on general comments and concerns from the perspective of the CTU.

2. Issues

Intent of the HPCA Act review

2.1 We are not clear on what the intention of the review is or what it is seeking to achieve. In our view the HPCA Act is not in need of major change and if there are problems with the operation of the HPCA Act we believe the status quo provides much of the necessary solutions to address any potential problems.

2.2 In our view the discussion document lacks enough information, cost-benefit analysis or rationale of the problems of which the review of the HPCA Act is attempting to address. We are concerned that if there are changes to the HPCA Act there may be unintended consequences due to the lack of evidence and benchmark information. There needs to be further consideration of evidence, analysis of problems and available options, and likely impacts.

Amalgamation - Secretariat Functions of 16 Regulatory Authorities

2.3 Although there may be efficiencies to be gained from amalgamating secretariat functions of the 16 Regulatory Authorities (underway by Health Workforce New Zealand), we have serious concerns around the implications of a shared secretariat service given the complex roles, potential loss of accountability mechanisms and autonomous nature of Regulatory Authorities (particularly larger Authorities).

2.4 It is not clear what the true objective or intent is of the amalgamation. We strongly believe the Regulatory Authorities (particularly larger Authorities) should remain free from political influence and retain a role in maintaining quality regulation. Although efficiencies may be gained from amalgamating secretariat functions, the CTU strongly believes this should not come at the cost of effectiveness, autonomy or roles of Regulatory Authorities.

Workforce Planning and Information

2.5 The discussion document gives the impression that HPCA Act may be used to address inefficiencies and workforce issues such as a lack of robust and reliable data. Our view is that the HPCA Act should not be seen as a mechanism for addressing what is essentially a longstanding problem of poor workforce information in the health sector. We agree that there is a strong gap in reliable and robust data collection of both the regulated and non-regulated workforce and subsequent workforce planning. Nevertheless, this is not the purpose of the HPCA Act but
rather of other groups such as Health Workforce New Zealand who have been specifically tasked with the role of workforce planning of which workforce data collection is and should be a pre-requisite.

Scopes of Practice

2.6 The discussion document refers to reviewing scopes of practice to support workforce flexibility. We consider the HPCA Act is already operating in a flexible manner. We have concerns in respect of the interface between regulated and non-regulated workforce and potential issues that may arise between professional boundaries and scopes of practice for practitioner groups. These concerns include blurred lines of accountability, responsibility and the risk of promoting a generic health workforce which could have serious implications for the health sector in future.

2.7 A lack of clarity around the review of scopes of practice in the discussion document may suggest that there are other underlying motives which are not being clearly communicated to stakeholders in the health sector. Our view is that a key aim of the HPCA Act should be to ensure there are adequate systems and processes in place to address potential workforce "boundary" issues and which maintain independence and effectiveness of roles.

Risk Assessment

2.8 We consider the HPCA Act is sufficiently clear on the level of risk assessment. We urge caution in respect of any changes that may seek to restrict, broaden or take a “one size fits all” approach to risk assessment given the varied levels of risk for each practitioner group.

Inclusion of other professional groups to HPCA Act

2.9 The CTU supports the inclusion of additional professional groups that may wish to come under the HPCA Act but we believe there should be robust processes including criteria for any Group wanting to join. This process must not undermine the intention or credibility of the HPCA Act and seek to ensure public safety, trust and confidence in the system.

Transparency and accountability of processes

2.10 The CTU supports greater transparency of information and processes but recognise this may be more difficult to administer and achieve in some instances e.g. non-regulated workforce.

2.11 Whilst we recognise the importance of having sufficient protections around safety, we note there are privacy issues to consider in respect of any change that would look to promote greater transparency and information sharing. We urge caution where the rights of either the consumer or practitioner may become compromised.
2.12 The CTU also recognises that whilst better consumer representation mechanisms are beneficial in respect of accountability, we do not believe this is an issue for the HPCA Act as there are other available avenues in which good consumer representation can be either enhanced, achieved or democratically recognised.

3. Conclusion

3.1 The intention or the outcome of what the HPCA Act review is seeking to achieve is not entirely clear. Whilst we acknowledge the work that has been put into developing the discussion document we do not believe there is enough evidence, information of problems or a robust cost-benefit analysis which may warrant major changes to the HPCA Act.

3.2 The CTU considers the HPCA Act is currently operating well but recognise that there could be some changes made to enhance the operation and effectiveness of the HPCA Act. However, we urge caution in moving too fast in finalising any changes as there is the potential for unintended consequences to occur which may have serious implications for the health sector and public.

3.3 The CTU welcomes further opportunities to provide input into the review of the HPCA Act. As part of future consultation processes we suggest that common areas of interest or key themes be identified as part of the submissions analysis process and which can act as a basis for future consultation forums.
How to have your say

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

You can download and email the submission form to:

info@healthworkforce.govt.nz

or post your submission to:

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

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

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

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

This submission was completed by: (name) Professor gregory Seymour

Address: (street/box number) (town/city) Faculty of Dentistry, 310 Great King Street Dunedin

Email: gregory.seymour@otago.ac.nz

Organisation (if applicable): Faculty of Dentistry, University of Otago

Position (if applicable): Dean

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
☐ Pacific ☐ Māori
X Academic/research ☐ 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
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:

Integrated care is best achieved by ensuring an integrated educational process and in the case of dentistry this is being hindered by the challenges in recruiting the best staff. World wide there is a shortage of suitably qualified academic staff in dentistry. In this context it is difficult for New Zealand’s only dental school at the University of Otago to compete. The need for internationally trained staff to obtain registration with the Dental Council presents as a final obstacle further discouraging suitably qualified people from coming to New Zealand. The Dental Board of Australia offers limited registration to overseas trained academic staff allowing them to have clinical duties within the University but not in the private or public sectors. A similar arrangement allowing limited academic registration is essential if we are to attract the best qualified staff from around the world.

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

Comment:

It is essential that the HPCA allows for the registration of suitably qualified academic staff and international postgraduate students to ensure that students are exposed to the best staff world wide. At present postgraduate students are unable to be involved in the clinical teaching of undergraduate students despite this being a recommendation of the postgraduate accreditation panel. While New Zealand and Australian trained postgraduate students are able to teach in accordance with the Dental Council accreditation recommendation, international students cannot. This ultimately will significantly disadvantage New Zealand as international students will go elsewhere.
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:

By allowing for a more flexible approach to registration for dental academic staff and international postgraduates, dental education will have a wider focus as students will be exposed to a wider range of approaches from around the world.

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:

No 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:

No 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:

No 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:

No 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:

No Comment
9. Do we have the right balance of laypeople to health professionals on RA boards?
   - Yes
   - X No
   - Not sure
   Comment:
   
   As accreditation of education is an essential role for the RA a greater involvement of the educational institution is essential. The Faculty of Dentistry has not been involved in making recommendations for appointment to the Dental Council and this is reflected in misunderstandings and relatively poor relationships between the University and the Dental Council.

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:
    
    No Comment

Safety focus

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

Overall quality of services is best underpinned by best quality of education and in this context the University of Otago needs to be able to attract the best quality of staff internationally and at present this is being hindered by the inability of the Dental Council to offer limited registration for overseas trained academic staff. This is available in Australia such that we are not competitive in attracting these staff to New Zealand.

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: No 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:

No 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:

No Comment

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

☐ Yes
☐ No
☐ Not sure
2012 Review of the Health Practitioners Competence Assurance Act

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:

   No Comment

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

   No Comment

21. Could the way RAs administer their functions be improved?
   - [X] Yes
   - [ ] No
   - [ ] Not sure
   Comment:
Greater flexibility and cooperation would significantly improve their relationships with professional and educational bodies which would be in the best interest and safety of the public.

22. Should RAs be required to consult more broadly with relevant stakeholders?
   - [ ] Yes
   - [X] No
   - [ ] Not sure
   Comment: Excessive consultation delays decisions.

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

24. What is the ideal size of RA boards?
   Comment: No Comment

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

The issues for the University of Otago Faculty of Dentistry are:

1. Registration of overseas trained staff to allow them to teach and have clinical duties within the Faculty so that New Zealand is competitive in attracting the best qualified staff world wide. This will improve the quality of dental education and ultimate will be of benefit to the people of New Zealand. Such registration is available to Australian Universities and as such gives them a real advantage in recruiting staff.

2. Registration of international postgraduate students so as to enable the Faculty of Dentistry to comply with the recommendation of the Dental Council accreditation panel. Again such registration is available in Australia giving them an advantage in attracting the best international postgraduate students.

3. Involving the University in making recommendations for appointment to the Dental Council so as to improve relationships and allow for a more cooperative approach to ensuring that all practitioners are appropriately trained at all levels throughout the professions of dentistry.
26 October 2012

Ms Brenda Wraight
Director
HPCA ACT Submission
Health Workforce New Zealand
National Health Board, Ministry of Health
PO Box 5013
Wellington 6145

Dear Ms Wraight,

HPCA Act Submission

Enclosed please find the Chiropractic Board’s submission on the Health Practitioners Competence Assurance Act 2003 discussion document dated the 31st of August 2012. The Board would like to thank Health Workforce New Zealand (HWNZ) for the work they are doing in conducting and facilitating the review process. The Board appreciates the opportunity to provide a submission and is confident that its submission will be considered in detail during the Act review process.

The Board would like to express its disappointment in the short consultation period on such an important issue and the Board would have appreciated more time to consider the issues and necessary response. Additionally, the Board would like to voice its apprehension that the underlying tone to the questions and areas of focus are fiscally orientated. The Board is concerned with tying public safety in the health arena to monetary spend by the regulatory authorities, which as you will be aware is not directly linked to government aide but rather a bill that is borne by practitioners.

The Board took the opportunity to attend the HWNZ RA consultation meeting in Wellington and also the professional consultation meetings in Auckland and Christchurch. The Board would like noted that there were less than 50-60 people in attendance at the Auckland presentation and less than 20 in Christchurch, and cautions that this is indicative of poor notice of the review. The Board is concerned that this is in no way indicative of the healthcare workforce of New Zealand and it would hope that HWNZ does receive a large number of submissions that it may draw on in considering changes to the Act.

Sincerely,

Angela Sinclair
Registrar

Attached: Chiropractic Board HPCA Act Review Submission
Review Submission

Health Practitioners Competence Assurance Act 2003

The Chiropractic Board has reviewed the 2012 Review of the Health Practitioners Competence Assurance Act 2003 discussion document and makes the following submission.

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 Board does not consider that this is an area the Act should legislate. Overall the Board sees integrated care as best for patients, but acknowledges that it requires a paradigm shift at the practitioner level and not at the RA level.

As a profession the Board notes that in general chiropractors work in relative professional isolation. The Board is of the opinion this is due to a number of biases and prejudices that have been long held by other professions and the fact that there is competition from a number of health practitioners for the same health dollars of an individual’s discretionary spend. The Board is of the view that these issues in particular need to be addressed; this would only be achievable through a paradigm shift in the thinking and planning of healthcare future strategies. While integrated care has been shown to improve patient outcomes and safety the Board questions how this would develop and who would oversee the process of integrated care. The Board would also require assurance that no undue burden of cost is passed onto registrants. The Board observes that conflicts could potentially arise due to professions differing best practises.

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

The Board would like to highlight that this question considers using the Act to fix a problem (subjectively held that there is a lack of medical and nursing practitioners to meet demand), however it does not address the root issues of the declining health and health challenges faced by the public; it is not the Act’s purpose to fix these problems. The Board is of the view that the Government should not use the Act to be reactive to problems, but rather that the Government should be proactive in addressing the causes of health challenges and by proxy workforce issues.
In considering a more flexible workforce the Board suggests that there be recognition in the Act for professional specialties; this would result in not “doubling up” on services and provide for cost savings, and quicker patient care. The Board also suggests that the Act support an environment in which clinical information is shared so as to cut back on duplication of services and also encourage collegial working relationships across the professions.

For example, in the use of diagnostic imaging a chiropractor, within the scope of their practice, may:

- take or order x-rays as an analytical tool used in the detection, location, evaluation, reduction, correction and monitoring of spinal and / or non-spinal articulations, dysfunctions, and to determine structural integrity, anomalies, mobility / immobility, and contraindications to chiropractic care;
- utilise other diagnostic modalities consistent with chiropractic practice including for example: neurocalometry, thermography, surface electromyography (sEMG);
- order or make recommendations for other such diagnostic or analytical tests consistent with chiropractic practice including by way of example: bioanalytical laboratory tests, diagnostic musculo-skeletal ultrasound, radiology, computerised axial tomography (CT), magnetic resonance imaging (MRI), radio-isotope bone scan, invasive electromyography and nerve conduction studies.

Often general practitioners and/or specialist medical practitioners repeat studies already undertaken by a chiropractor; this is inconsistent with the National Radiation Laboratory safe practice guidelines. In addition, Chiropractors are not given permission to order the above studies under ACC and many facilities will not accept from a chiropractor a referral for these studies to be preformed, resulting in delayed patient care at a greater cost to ACC and detriment to the patient.

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?**

   This is seen as beyond the scope of the Act, as the primary purpose of the Act is to protect the health and safety of the public through regulation.

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

   The Act should ensure minimum standards in each of these areas while recognising that RAs will have to develop specific approaches relevant to their profession. These profession specific standards would arguably be more detailed and must be set at a higher level, or meet any baseline standard.
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?

Please refer to our response to question 4. The Board would also take this opportunity to strongly counsel against over regulation.

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

There is an intrinsic tension between ‘pastoral care’ and the regulation of and supervision of standards of a profession. If pastoral care is seen as an important issue by the Government then it may need to consider developing another agency to provide for pastoral care of health practitioners, as the Board does not see any pragmatic way to improve on this through the Act. The Board notes that historically any pastoral care that has been provided to practitioners has been through professional organisations.

Consumer Focus

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

A. No, the HPCA Act keeps consumers of regulated health care practitioners safe, however it has no jurisdiction over the public at large who may choose to seek ‘care’ from unregulated providers. Protecting the public from unregulated and unregistered practitioners falls under the responsibility of the Ministry of Health. The Board has found that the Act does not provide for a depth of support and services for those in the Ministry pursuing cases of unregistered practitioners.

B. No, consumers do not understand the Act, its purpose or the role and purpose of the RAs, and they are not sufficiently informed about the Act; therefore they cannot be appropriately involved in decision making. It is through the involvement of lay people on the Board that the public is represented; the Board sees this representation as essential.

C. No, please see B above.

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?

In the Board’s view appropriate information is readily available to the public and the level of transparency is satisfactory. Confusion exists over the differing roles of the Health and Disability Commissioner and RAs in dealing with complaints. Greater publicity and public education is needed to clear this confusion as even some practitioners are unclear on the distinction.
9. Do we have the right balance of laypeople to health professionals on RA Boards?

Yes, our Board is well served by two laypeople.

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

No, the Board does not think it is appropriate or necessary to have consumer forums communicating directly to an RA with regards to regulation. It is felt that through the consultation process that all RAs engage in there is already an adequate existing mechanism. Additionally, RA decisions are based on the responsibilities, requirements and authority provided by the HPCA Act and not on popular opinion.

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?

The Board is confident that the HPCA Act is being well applied. However, different legislations that have a role in protecting the public could 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 HPCA Act do this to some extent, but important legislations such as the Privacy Act 1993, Health Information Privacy Code 1994 and the Medicines Act 1981 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, Accident Compensation Corporation (ACC), the employer and the RA etc. It can be very confusing for both the health consumer and practitioners, resulting in people getting shunted from one agency to another and will often give up before they get the answers they need. For this reason it is important for each of these agencies to be in regular communication 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?

As chiropractors do not work for DHBs or generally in large employer/employee relationships this is not an issue our Board is in a position to respond to.
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 reference our reply 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, the Act is not clear about the level of risk that needs to be regulated by statute. But this lack of a definitive level is acceptable in that it gives RAs the ability to determine what the acceptable level of risk for their profession is; this is a positive as risk levels are profession specific. Many topics, including setting levels of risk, are discussed collaboratively among the Registrars and RAs, providing the opportunity to gauge risk policies among the health professions.

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

The Board is currently in the process of implementing a CPD programme which will work to assist practitioners in internally and externally identifying and managing their risks and also provide a tool to the Board in identifying individual practitioners who may have potential risk issues.

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?

No, risk profiling is not seen by the Board as helpful, the Board currently uses other mechanisms to observe high risk groups, these mechanisms include – complaint tracking and the CPD programme. Practitioners at risk are better served on a case by case basis.

Cost Effectiveness Focus

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

The Board is disappointed that there is an expectation that public health and safety be directly related to cost. The Board does appreciate the importance of cost effectiveness and currently works within tight financial constraints, is audited yearly and allowed to maintain limited reserves. Profession APC fees are set at the lowest prudent level to ensure the Board is able to meet its obligations and responsibilities under the HPCA Act. The Board notes it has no control over the costs associated with the HPDT, resulting in the final step of the Board’s complaint process being outside the financial control of the Board and yet the Board is liable for
all associated costs. The Board also notes a lack of direct funding from the government for the regulation of health practitioners.

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

No, harm is profession specific and therefore the Act is sufficient as currently written in allowing the individual RAs to define harm for their professions. In additions the Board notes that harm is defined elsewhere in legislation specifically in the Accident Compensation Act 2001, it would be logical for the HPCA Act to reference the ACC definition.

19. 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, while the five (5) restricted Acts may be clear, they are not publicly known or easily located by the public. As these five restricted acts are little known to the public, the Act is failing in its purpose to keep the public safe, as without knowledge of these restricted acts the public is unable to make informed health decisions. Increased publicity and education as to these five restricted acts would work to protect the health and safety of 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?

Yes.

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

It would be premature for the Board to answer this question as the amendments from the operational review of the Act have yet to be put in place and we are unaware of what changes may take place. Also it is important to note that the Board administers its functions under strict guidelines from the Auditor-General, which ensure cost efficiencies.

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

The Board is of the strong view that it has positioned itself in a situation in which it is working in a very cost effective and collaborative fashion. As part of HRAS (Health Regulatory Authorities Secretariat) along with the Optometrist and Dispensing Opticians and Dietitians Boards, the Board enjoys a frugal and financially stable existence, while maintaining good oversight and management of its obligations and functions.
A distinction needs to be drawn between improving the way RA functions are administered and achieving cost efficiencies. This question is listed in the ‘Cost effectiveness focus’ section, the section in the discussion document draws comparison with consolidations of RA secretariats in overseas jurisdictions. However, while some efficiencies have undoubtedly resulted through the consolidation of secretariats, and would most likely 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 (additionally cost savings was not the goal in Australia as clearly noted on page 30 of the discussion document).

As directed by the Minister, the Board continues to consider options for a shared secretariat. In this consideration the focus has been on ensuring that there is no loss of effectiveness of the Board and in upholding the following principles:

- That each RA will be permitted (if they so choose) to directly employ and control any and all specialist ‘regulatory’ staff (i.e., those staff that carry out the specialist functions under Parts 2, 3, and 4 of the Act). A corollary of this is that each RA will determine for itself who its specialist regulatory staff will be and how many it will employ at any given time.
- That each RA’s current instruction and accountability chain is not lengthened.
- That each RA’s regulatory decisions are all made by either the Board/Council or its delegate(s) (in order to ensure the on-going direct involvement of the Board in these decisions).

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

No, as currently required is sufficient.

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

No, the current set up of the Boards works well for the public and practitioners.

24. What is the ideal size of RA Boards?

The ideal board size is eight to twelve members (8-12) with two (2) lay members. This is in line with a number of studies and research papers that have come out from the United Kingdom where consolidation of Board numbers has been implemented.

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

1. The Board thinks that in order for the HPCA Act to more fully meet its purpose of protecting the public that the Ministry of Health needs to be enlisted with the task of better informing the public about the Act, its purpose, the RAs and their purposes. A simple way to start with this is to provide more clear
information as to the Act and RAs on the MOH website. With the public uninformed, the Act will be unable to fulfil its purpose of protecting public health and safety.

2. There is a significant failing in the Act currently with regard to protecting public safety with regard to the weakness of s 7 of the Act – “Unqualified person must not claim to be health practitioner.” Enforcement of this section falls to the Ministry of Health. Situations do arise in which unregistered people hold themselves out as practitioners and this is a significant risk to public safety and improved strategy in regard to enforcing this restriction needs to be included in the Act.

3. To support a future workforce changes need to be made to education funding. In particular, chiropractic education should be funded at the same level as other health practitioner education is funded. This needs to be done to ensure that there continues to be a steady supply of well educated chiropractors available in the work force to treat the public of New Zealand.

4. In regard to the potential duplication of services that has previously been mentioned by the Minister and by Professor Gorman, the Board is against a return to a gate-keeper model which removes the ability of a consumer to make their own informed choices about healthcare.

5. The Board has recently faced a situation in which a practitioner was convicted of a crime and served jail time, the Professional Conduct Committee did not recommend that a charge be brought before the Tribunal but did make recommendations under s 80 (2) (a), (b) and (e) of the HPCA Act. As the practitioner remained on the register the Board could not make considerations under s 16 of the Act. This situation highlighted to the Board its inability to remove practitioners from the register, the Board is of the opinion that in certain situations the Board should have the authority to remove practitioners from the register.
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: Vanessa McQueen Court

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Email: naturopath.acvm@ihug.co.nz

Organisation (if applicable): Naturopaths of New Zealand

Position (if applicable): President

Are you submitting this as:

(Tick one box only in this section)

- [x] on behalf of a group or organisation(s)
- [ ] an individual (not on behalf of an organisation)
- [ ] other (please specify): ..........................................

Please indicate which sector(s) your submission represents

(You may tick as many boxes as apply)

- [x] Consumer
- [ ] Academic/research
- [ ] Pacific
- [ ] Education/training
- [ ] Provider
- [x] Non-government organisation
- [x] 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?**

- [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. We feel 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, hypnotherapists, physiotherapy, chiropractics, osteopaths, massage therapists, yoga therapists, naturopaths, medical herbalists, homeopaths, traditional Chinese Medicine, acupuncture, Rongoa Maori healers, Ayurveda practitioners, Kinesiologists].

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
- Accreditation and monitoring of education providers
- Sets & monitors criteria for Continuing professional development
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 allow entry into a health workforce whose potential is underutilised in the spectrum of healthcare. Integration (of CAM and CC) is unlikely to be fostered without such recognition. 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). This would create a greater ability to respond appropriately, given the greater understanding created by spending more time with patients. Funding given to health promotion and disease prevention if it were able to be utilised through 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. dieticians, nutritionists, naturopaths, psychologists, psychotherapists, counsellors, hypnotherapists. Limitations could be set around level of scope of practice e.g. dieticians 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. **Deleted[N]: 15**
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:

This 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
• 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.
- RA’s 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 RA’s.
- All CPD could require online CPD examples of breach of codes of conduct & ethics as an ongoing education requirement (as opposed to RA’s 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 RA’s have a mandated role in health professionals’ pastoral care? If so, how can they carry this out?

X Yes
☐ No
☐ Not sure

Comment:

Deleted[N]: 15
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 to cover all community based workers to ensure the health & safety of the health professional & to prevent burn-out & errors being made. 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, Kinesiology, Hypnotherapy).
   Other CAM practices should be required to have 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:
Recent complaints made against complementary therapists are made in the public arena (newspapers, television) and occasionally reach the associations. These often involve practitioners who are not known to, or are members of professional organisations. (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
X 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 could also be three consumers/lay people on an RA board: a lay person, at least one Maori rep. & a disability rep. 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?

X 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:

   Current legislation covers the consumer for safety and access to complaint procedures eg Health and Disability Commissioner

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, Kinesiologists.

   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?

   Deleted[N]: 8
If not, what would help to improve the match between level of risk and level of regulation?

☐ Yes
X 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 if 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, Kinesiology 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:

One option would be for Peer review systems in 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?

X 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 and consultation.
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:

Deleted[N]: 8
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
X 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?

X 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?

X Yes
☐ No
☐ Not sure

Comment:

Deleted[N]: 15
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

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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.

<table>
<thead>
<tr>
<th>This submission was completed by:</th>
<th>Beverley Burrell, Jennifer Conder, Sandra Richardson and Lisa Whitehead</th>
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<td>Position (if applicable):</td>
<td>Senior Lecturer</td>
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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
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**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 existing system appears to be working effectively, no clear need to alter this. In our view the HPCA is functioning effectively. A substantial review seems wasteful of health sector time and Vote Health money.

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 system as it stands appears to be sufficiently responsive and flexible – there have been changes to existing scopes and processes that indicate the system is responsive to changing workforce needs, while still maintaining professional boundaries. While there is clearly a need for multidisciplinary and integrated service provision, and there are some generic aspects to health care, the individual professions still offer something unique to each which risks being lost if a single, homogenous and non specific approach is taken to healthcare registration.
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 tick boxes above this section are inappropriate to the question asked. There appears to be a clear process within the current HPCA Act to allow for review and accreditation of existing educational processes, and there is already a commitment within the Act to maintaining a collaborative approach. This is further evidenced through individual professions set competencies, where this not only an expectation but a requirement.

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 current professional codes of conduct and ethics appear to be working effectively at present, there is no clear need for change identified at this stage. There is no suggestion that the current variation presents confusion or risk to public safety.
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:

While current scopes of practice descriptors vary between professions, there appears to be sufficient information and detail to allow both lay people and other colleagues to identify the role and expected competencies of a registered health professional.

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 is currently (and should remain) outside the scope of the RAs. Introducing pastoral care requirements has the potential to blur the role of the RAs, introducing a conflict of priorities and causing potential risk when the RA is faced with managing disciplinary issues at the same time as pastoral care support. The current disciplinary tribunal allows for support of health professionals from other agencies, eg professional bodies, employers etc and this is where the focus should remain.

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:
The existing system is sufficiently transparent.

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:

It is unclear that this would contribute significantly to public safety

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

- Yes
- No
- Not sure

Comment:

These functions must be independent to avoid conflict of interest between the employer and employee and also between the employer and the public.

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 are areas of potential overlap, but no evidence that this is sufficient to result in redundancy of effort. Consideration needs to be given to the restrictions imposed on practitioners by the current ACC regulations and the definitions of approved providers.

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: No need to change

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:

The existing processes appear to be sufficient.

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 costs in rises in fees are not prohibitive, RAs appear to have been responsible in setting practicing certificate rates.

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:
Again, no evidence to suggest this is problematic has been identified.

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: No need for change

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:

   Although there could be some rationalisation, we totally reject the notion of a single regulatory authority for health professionals as has been proposed by the current Minister of Health and supported by HWNZ.

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

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This submission was completed by: Jane de Lisle

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<td>Position (if applicable):</td>
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- [ ] 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 principal purpose of the HPCA Act is to ‘protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions’.

This should be paramount at all times - the Dietitians Board would be very concerned if changes to the HPCA Act meant that minimum standards only are set for the future - as this would pose real risks to the public’s health and safety.

The Dietitians Board believes that the current HPCA Act is working well, is flexible and fit for purpose, but is open to considering minor changes such as Consumer Forums and further analysis of legislation overlap or gaps.

The HPCA Act requires Regulatory Authorities (RAs) to define their ‘Scopes of Practice’, to prescribe the qualifications necessary to work within the scopes and the standards that health professionals need to abide by.

Refer also to Q2.

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 new National Certificate in Health, Disability and Aged Support (Health Assistants, e.g. Dietitian Assistance) from CareerForce is a potentially powerful innovation. If it works well, health professionals may be used more at the 'top of their scope', leaving the 'assistants' to undertake delegated tasks.

The Board would not be in favour of different health practitioners being employed under generic job descriptions, and especially those not covered by the HPCA Act, as this would carry a safety risk to the public. What training would they undertake? Who/what RA would they be accountable to in this case?

Dietitians already work in healthcare settings including hospitals, in teams with Nurses, Doctors, Occupational Therapists and other Allied Health professionals. Therefore, multi-disciplinary teams (MDTs) are already functioning well.

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

(tick boxes not relevant for this question)

Comment:

Individual RAs are already responsible to ensure that the competency requirements being taught by the training providers are appropriate, before a health practitioner can be registered.

The Dietitians Board’s ‘Statement of Registration Competency Requirements’ for instance, already requires that new graduates ‘conduct effective communication’ and ‘conducts him/herself as an effective team members and understands team leadership’.

Monitoring and accreditation of education providers could be better defined under the HPCA Act, to ensure that ‘consistency and best practice’ applies across all RAs.

Additional education and training should be carried out at a postgraduate level, i.e. after the (minimum) qualifications have been met for working in a particular scope of practice.

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 RAs already share policies and standards, cooperate, and consult with each other as stakeholders as necessary. The HRANZ Intranet is also a forum for sharing such documentation as needed.

Changes to the HPCA Act are not needed to make this happen - however the proposed single shared secretariat for RAs may be a catalyst for standardisation across the RAs in areas such as codes of conduct.

Although generalised codes may be acceptable, and in most cases are already similar, many professions do have specific requirements which would need to be added to the core Codes, e.g. under the Dietitians Board’s Code of Ethics, dietitians do not endorse specific products/brands to the public.

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

☐ Yes
☐ No
☐ Not sure

Comment:

Yes, ‘Scopes of practice’ are already quite broad. Job descriptions should specify what an individual practitioner may perform/ not perform within his/her Scope of Practice.

RAs websites inform the public of what to expect from their health practitioners.

If other communications with the public are instigated, there would likely be a cost impact that is not already budgeted for. This expenditure would need to be balanced against other key activities. The Dietitians Board is reluctant to increase APC and registration fees. Therefore, cost/benefit analysis would be required.

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, employers and associations should do this as and when required.

If this was the responsibility of RAs, it would create role confusion.

As RAs register (and discipline) health professionals they are not best placed to provide pastoral care in general.

RAs do however have a role in recommending/requiring supervision and/or mentoring-the Dietitians Board demonstrates minor pastoral care by the above means, i.e. being supportive rather than punitive, if and when the need arises.

Most RAs responded to the Christchurch Earthquake by allowing their practitioners to take longer to complete the renewal requirements for APCs-this was a form of compassionate pastoral care at that terrible time.
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
x☐ Not sure

Comment:

The HPCA Act keeps the public safe, as well as any legislation can. Not sure-regarding involving consumers in decision making. The suggested ‘Consumer Forums’ may have some potential benefits. The Dietitians Board would like more information on how the Ministry of Health sees Consumer Forums being structured so a Terms of Reference would be helpful also. Refer also to Q10. The HPCA Act could set clear standardised expectation on how to improve transparency and consumer communications.

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
x☐ No
☐ Not sure

Comment:

RA websites usually contain information regarding processes, but not outcomes, of complaints. The Public Register on the Board’s website gives basic information, such as Active or non-Active and conditions on the Scope, including supervision. Since the commencement of the HPCA Act in 2004, the Dietitians Board has only has one ‘complaint’ from a member of the public. This may largely be a reflection on the Continuing Competency Programme that the Board has had in place since 2004, which helps keep dietitians safe to practise.

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

x☐ Yes
☐ No
☐ Not sure

Comment:
Yes, it is important to have at least 2 laypersons on the Boards/Councils, depending on the total Board numbers, and to enable a quorum (if one is away). They must be able to take time off their usual place of work as needed and to contribute effectively and neutrally, to the Board’s business.

Lay people should be appointed on merit through having governance, financial or other appropriate skills, and a strong interest in helping ensure the health and safety of the public. The Dietitians Board currently has two lay members who are contributing effectively and are committed to working with the Board to protect the health and safety of the public.

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:

These are worth considering, but these should be optional for RAs to undertake. However in reality, these would cost - in time and money. Clear parameters would need to be set to include: how these would actually work; who would organise them; advertising for membership of forums; who funds them (Ministry of Health?); and what the purpose of the forums is.

If instigated, the Ministry of Health must offer guidance and best practice for RAs on undertaking Consumer Forums, as well as the Ministry’s expected desired outcomes.

Would a subcommittee of RAs, the Ministry of Health and the public be the answer to setting the desired parameters of Terms of Reference for Consumer Forums? Research from Consumer Forums overseas should be studied and considered.

Refer also to Q7.

Safety focus

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

- Yes
- No
- x Not sure

Comment:
The HPCA Act works well - it is a comprehensive document with flexibility as needed, to help keep the public safe from harm.

However there are overlaps with other legislation, particularly the Health Disability Commissioner’s (HDC) Act, and these may need to be made clearer - to the public, health professionals and to the RAs (e.g. by cross referencing the appropriate section of the Acts).

The HDC Act may need to be made more visible to the professions as the two Acts work in conjunction with each other. The legislation can be confusing, e.g. Sections 34 and 35 of both Acts are similar.

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:

Refer to Q 11 also.

It is important that employers are aware of the need to employ regulated health practitioners whenever possible and feasible, to reduce the risk of a non-regulated practitioner breaching public safety. Regulated health practitioners must practise within their scope of practice, abide by the RAs competency programmes and other standards, and work within their own area of competence. The HPCA Act therefore encourages practitioners to remain accountable for their own clinical practice and thus their own competency.

This concept requires closer scrutiny and the RAs currently are not party to the finer points of legality being sought. This is a topic that requires more investigation and the Dietitians Board would support the MoH considering this investment. We look forward to any findings and would consider any subsequent recommendations.

The Board is aware that at least some of the DHBs do have performance plans/peer review systems already in place, which are employer risk based management systems. However many health practitioners do not work within DHBs and a number are self-employed and therefore employer-based risk management systems do not exist.

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 is vital for the health and safety of the public to ensure that the HPCA Act is not weakened to allow minimum standards of competence only to be maintained.

Refer also to Q11.

The Board would again welcome the Ministry of Health investigating this through independent means and look forward to detailed findings and recommendations to consider any specific changes.
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  x☐ No  ☐ Not sure

Comment:

‘Low risk of harm’ and ‘serious risk of harm’ may need defining - currently this is not clear in S35 of the HPCA Act, however the lack of definition does give the RAs more discretion in what level to apply the risk of harm to.

The various agencies listed in S35 (1) (a) possibly need more guidance on procedures once a risk of harm has been notified to them.

The HPCA Act enables RAs to mitigate risk by setting standards of clinical competence (Continuing Competency Programmes), ethical conduct, and cultural competence (S118(i)).

Improved training, and clear standards may suffice for some of the health professional groupings that are currently non-regulated, to provide sufficient protection for the public - other groupings do not all need to be regulated. Some professions do carry a greater level of risk than others (refer Q16 also).

The Dietitians Board feels that it is entirely appropriate for the profession to remain regulated. All RAs that have a related Restricted Activity (e.g. Dietitians) should continue to be regulated, to mitigate potential risks of harm.

Not one RA, nor person, nor agency can control risk totally, but RA policies and subsequent programmes, standards and codes help practitioners manage risk.

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

Comment:

Yes, dietitians in private practice, especially those working in isolation, are often the cases that the Dietitians Board have found to be of concern with potential risk to the public. These practitioners should be required to have professional supervisors at least in the first year of private practice as a matter of course, with on-going supervision thereafter if there appears to be any risk - an addition to the HPCA Act may need to be made to enable RAs to easily put this in place. They should also continue to be encouraged to be mentored, and be active networking with other registered dietitians at training and conference opportunities.

The Board does not believe that an additional levy should be applied to these groups within a profession however, as it would be impossible to police: e.g. many dietitians work in private practice, as well as at a place of employment, or alternate during their career.

Note: Entry level practitioners (e.g. dietitians) generally work in teams-mainly in DHBs or PHOs and therefore have supervision/mentoring and on-going support. Practice supervision is a requirement for entry level dietitians.

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?
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 Dietitians Board is already very careful not to spend unnecessary money, as its income is received solely by dietitians APC fees, (and registration fees etc).

RAs are accountable to the Minister of Health. RAs are obliged to write an annual budget and if the fees need to be subsequently increased, they must consult widely with their profession and stakeholders-explaining how/why they reached the new figure. The increased fees must be gazetted before coming into effect, and may be queried by the Regulations Review Committee. The RAs are also audited annually-a financial and performance audit.

The Dietitians Board believes that its Continuing Competence Programme (CCP) requirements are necessary to help ensure dietitians practise safely, however these CCP requirements have become easier to meet since April 2011 through the instigation of its online CCP, yet do not compromise safety.

NB: Certain activities such as referring practitioners to the HPDT or PCCs carry huge costs (paid for by other practitioners). Fortunately the Dietitians Board has not had to refer any dietitians to HPDT or PCC. However, it has undertaken competency assessments.

Cost effectiveness should not compromise the functions of the RAs or the HPCA Act.

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:

The HPCA Act is not clear about the level of risk that needs to be regulated by statute. Some explicit guiding principles would be helpful.

Boards/Councils also need the right mix of expertise for making policies/standards to ensure a balance between regulation and risk.

Refer also to Q14.

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:

RAs need to create a good balance for on-going competence requirements, to ensure the public is protected, yet the programme is not to be a burden on the health professionals. The Dietitians Board believes its online Competency Programme is achieving the right balance.

The Ministry should assist RAs in creating more public awareness of who is regulated and what this means.

Section 7 is not clear to the public.

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

☐ Yes  
☒ No  
☐ Not sure

Comment:
The Dietitians Board believes that it is already working effectively. The Dietitians Board is one of three Boards forming the Health Regulatory Authorities Secretariat (HRAS), and as such is working collaboratively, cooperatively and efficiently, with cost containment made through shared premises and services, which include financial and administrative support.

The RAs constantly look to improve their performances and to reduce costs, and are currently working towards all RAs working in a shared single secretariat.

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

- ☐ Yes
- ☐ No
- ☑ Not sure

Comment:

RAs, including the Dietitians Board, already consult with their profession, other RAs and stakeholders e.g. education providers.

The Dietitians Board currently only consults with the general public through the website, but will consider other ways and means to consult with the public in the future. We look forward to more information on structure and Terms of Reference of Consumer Forums from the Ministry of Health.

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

- ☐ Yes
- ☑ No
- ☐ Not sure

Comment:

No, the current Boards and Councils all have an essential role to play. The point of the HPCA Act is to ensure public health and safety, rather than reducing the professions and RAs.

Although there are more professions wishing to be regulated, some may be able to be incorporated within current RAs, using different Scopes of Practice.

Please also refer to Q14.
24. What is the ideal size of RA boards?

Comment:

It is important that the number of members on a Board/Council, who are working in the profession is balanced, as is now, with those who are lay members. 7-9 in total (depending on the size or complexity of the professions(s) being regulated), seems to work well in most instances - 2 or 3 of these being laypeople.

The Board has appreciated being able to recommend to the Ministry of Health, the skills required for each new member appointed as part of the nominations round, and being consulted before the nominees are sent to the Minister of Health for his/her approval. More speed in Board appointments would assist RAs to work even more effectively. Currently several Boards/Councils are awaiting Board membership appointments, which means that in effect, either a member is ‘hanging on in’ when their term has expired (as for the Dietitians Board), or they resign leaving Boards/Councils short of members. This effect is very unsettling and means less effective long term planning, as well as a greater workload for remaining Board members.

Regardless of size of the Boards/Councils, they still carry the same risks. A minimum number of members is still required to share the workload, write policies, consider complaints and competency/discipline/conduct matters. It is important to note that even if board membership is reduced, the costs remain similar as the work is required to be picked up by the other board members and they are paid on an hourly rate. So if more hours are billed by fewer members, the cost of the project remains the same. There is a risk that if board membership is cut to 5, 6 or fewer members, that board membership will become unattractive or untenable for professional dietitians as they cannot easily get the time off to cope with the increased workload. The Ministry should keep the role of a board person within the profession as an attractive one, so that the employer (often DHBs) are willing to support and therefore, to a point co-fund.

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

Comment:
The Board also wishes to make the following comments (not in any particular order):

1. More **cross referencing** is required within the HPCA Act, and to the HDC Act and others, e.g. S106 needs to be linked back to all of the appropriate sections in the HPCA Act.

2. Wider workforce issues e.g. **data collection** should remain outside the scope of the HPCA Act, as this is not specifically related to regulation.

3. The growth of **Internet services** over the recent years, may lead to substandard services not covered by the HPCA Act. A new section could be included in the HPCA Act, to assist RAs to advise guidelines on how to deal with cases - both of registered professionals practising on the internet outside NZ and those from other countries practising on NZ clients.

4. **Standards of care must not be compromised** by allowing those who have not met NZ criteria/standards, to work in NZ i.e. by 'lowering the bar'. Some of the competency problems in NZ with dietitians have arisen from overseas trained dietitians, who had already met the Board’s criteria by passing the examination, yet complaints regarding their communication skills and/or competence were later received.

5. **Employers** should help ensure safety by allowing practitioners to attend at least one study/professional development day, per year.

6. Good **communication** skills are critical for each and every health practitioner.

7. Clearer **guidelines** regarding setting **qualifications/accreditation** of programmes and monitoring of education training providers would be helpful, as setting the education standards create the basis for the future workforce. It is important to get this right.

8. The **Education** sector needs to align better with the Health sector, especially in regard of the numbers of health professionals it trains, which is currently done from a business point of view. The current ‘bums-on-seats’ tertiary sector policy is unfair, if many of these graduates have no work in NZ after training.

9. **Changes** need to be well planned and have a good rationale to minimise costs and the loss of valuable employees. Already in this unsettled period RAs have witnessed several resignations of key staff and a significant amount of money has been wasted on scoping models for change. This is not the most efficient use of Health Professionals’ APC fees and does not contribute to ‘ensuring public health and safety’.

10. The Dietitians Board has responded to requests by the Ministry and/or the profession, in supporting Dietitians to become prescribers, by increasing the accreditation of training programmes and encouraging the National Certificate in Health Assistance training programme.

11. The Act should amend the requirement for the Chairperson and Deputy Chairperson to be elected at the first meeting of each year, and allow this to be a matter of choice by the RA.

Finally, the Dietitians Board believes that the HPCA Act has improved the regulation of health practitioners by ensuring competence and professional development. Few changes, if any, other than those recommended in 2008, which are still before Parliament, should be made.