

21 December 2007

Ryan McLean
Sector Policy Directorate
Ministry of Health
PO Box 5013
WELLINGTON

National Office
Level 6
203 - 209 Willis Street
PO Box 11-515
WELLINGTON

Tel: (04) 384 4349
Fax: (04) 382 8356
Website:
www.familyplanning.org.nz

Dear Ryan

Thank you for the opportunity to comment on the Health Practitioners Competency Act 2003.

Family Planning is an independent service provider with a commitment to promoting a positive view of sexuality, informed choice, access to accurate information, and quality sexual and reproductive health services. We operate clinical centres, outreach and school clinics, a national resource unit, as well as providing professional training and education.

Family Planning provides clinical services through 32 clinics in 17 District Health Boards (DHB) and health promotion and education in almost every DHB area.

Review of the Health Practitioners Competence Assurance Act 2003

1. Is the Act achieving its purpose? Please explain.
Yes. It places greater emphasis on the monitoring and measuring of competence for groups of health practitioners who have not had formal programmes before (for example nursing).
2. What evidence supports your answer?
We are aware that the Nursing Council has put structures in place for ensuring nurses are maintaining competence. This includes auditing some nurses and making practice certificates competency based.
3. What, if any, comments do you have on the adequacy of evidence available about the success of the Act and any changes needed – including, for example, any reporting requirements that might ensure more open access to evidence that the Act is being effective.
We believe that the existing annual reporting process for registration bodies provides Parliament with adequate information. Reports to Parliament should not reveal the identity of organisations or individuals involved in the process.
4. Are the provisions in section 7 of the Act operating in a way that ensures that non-qualified persons do not claim or imply to be qualified practitioners and what, if any, changes do you recommend (note that issues around enforcing breaches are dealt with in the section titled 'Enforcement of the Act' which is set out below)?
The public are probably not aware of these provisions so may still be misled, but at least there is recourse to law if noticed. Many legitimate health practitioners may not advertise their credentials. We are happy with the current provisions.

5. Are the provisions in section 8 operating effectively and what, if any, changes would you recommend?

There is no specific monitoring on this although doctors are reminded that they should be practising within their scope when reapplying for Annual Practising Certificate (APC).

6. Are the provisions in section 9 and the current list of restricted activities operating effectively and what, if any, changes, amendments or additions would you recommend?

No recommendation for change.

7. Is the Ministry approach to enforcement of the Act in keeping with the purpose of the Act and what, if any, changes would you recommend?

Yes. No further recommendations.

8. Are scopes of practice achieving their intent? Please explain.

Yes, although it can be difficult to get agreement on whether particular health care practices fall under a specific scope when there are a large number of scopes such as in medicine and when several scopes overlap.

9. What, if any, comments do you have on the operation of the powers that registration authorities hold to allow conditions or authorisations on individuals' scopes of practice?

No comment.

10. Is the process for developing scopes of practice operating well (e.g., are there suitable mechanisms for ensuring scopes of practice reflect service need) and what, if any, changes would you recommend?

We are aware that current scopes of practice being reviewed by Medical Council and at least one scope has been de-registered and another is threatened with de-registration. This process seems to be a subjective and difficult process for organisations that scopes the practice to implement. However, we are unsure whether a change in the Act would alter this.

11. Do prescribed qualifications reflect scopes of practice? Please explain with reference to particular scopes of practice and considering whether a) the levels of qualification are too low or too high when considering their purpose of assuring public safety, and b) whether they meet the requirements of section 13.

Seem fine within medicine

12. With regard to their purpose of assuring the competence of registered professionals, how well are the current recertification regimes working (where possible refer to particular professions)?

Current recertification regimes still reflect activities more than competence and practice although if activities are undertaken well, they should reflect competence and practice.

13. What changes, if any, are needed to improve the evidence available to answer the previous question?

Actual observation of practice by peers/colleagues/team members to ensure that what health practitioners believe they are doing is confirmed

14. Where recertification arrangements are in place, what issues arise and what changes, if any, would you suggest (e.g., in respect of the nature of the programmes, the level of compliance, monitoring practitioners' compliance, the costs and other impacts on practitioners employers etc)?

Some of the activities are difficult for rural practitioners to complete e.g. enough peer review hours; difficult to institute any action for non compliance; costs if employer is to pay for these activities.

15. Where recertification programmes have not been introduced how do the authorities assure competence, and are there ways that these processes could be improved?

Unsure.

16. What would be the gains or problems associated with requiring all authorities to institute recertification programmes?

The benefit would be in knowing that health practitioners are keeping up to date. There would also be an increase in compliance costs that would impact NGOs such as Family Planning. Increases in compliance cost can mean less money is available for service delivery.

17. Registration authorities have to judge when a practitioner 'may pose a risk of harm to the public' and trigger notification: is this working effectively and what, if any, suggestions do you have to improve effectiveness?

Yes, this is working effectively. The Act makes it very clear that risk needs to be assessed and if there is a risk to the public considered and reported.

18. Is it appropriate that authorities must notify a particular set of agencies: what changes, if any, are needed?

Yes, no change needed.

19. At what times, if any, other than when there is a concern of a risk of harm to the public, should a registration authority exercise its power to review the competence of a health practitioner?

If the reaccreditation audit finds that the health practitioner is not fulfilling the requirements.

20. Is voluntary reporting by practitioners of possibly unfit practitioners working, on what do you base this opinion, and, in the light of experience, what are your views on making it a requirement to report concerns about a possibly unfit practitioner?

See 17 – We believe it is working much better than before the Act.

21. Is compulsory reporting by employers of possibly unfit practitioners working, on what do you base this opinion?

We believe it is working well based on experience within our own organisation.

22. Are the interests of the public and of practitioners being balanced when dealing with the risk of harm from practitioners who are deemed to fail to meet required standards of competence? Please explain.

Yes. The risk of harm to public is the yardstick.

23. In practice, do competence and recertification programmes differ, are both sets of provisions needed or should changes be made?

Competence programmes are largely about rehabilitation when weakness has been identified whereas recertification applies to all members of the health practitioner group.

Re-certification processes should be well considered so they are not a waste of energy and resources. An example of recertification being separate from competence is nurses endorsed to provide ECP needing recertification by Nursing Council after 5 years. Not necessary when competence can be shown through internal processes.

24. Should any other parties be obliged to inform the registrar of a practitioner's inability to perform their required functions because of a mental or physical condition?
No others need to be added
25. Are the interests of the public and of practitioners being balanced when dealing with fitness to practise issues? Please explain.
Yes. (see 22)
26. Are protected QAAs operating in areas you are familiar with: are they valuable, are there any problems, are the reporting requirements appropriate, should there be any changes to the QAA arrangements, should QAAs continue? Please explain.
They are working in our area and we are reporting regularly on them. However, the activities are those we were doing before the Act so reporting seems unnecessary. The only advantage is that the activities are covered by confidentiality.
27. Are PCCs being used by the registration authorities you are familiar with, how often and for what reasons?
We have no experience in this area.
28. To what extent is the suspension of an annual practising certificate and referral of a practitioner to the HPDT effective in protecting the public?
We believe this is very effective.
29. What, if any, additional steps should be taken into account when determining to suspend an annual practising certificate?
None.
30. What, if any, benefits or problems have arisen from having a single tribunal for all regulated professions and what, if any, changes would you recommend?
None.
31. Is the current membership structure of the HPDT operating and are there any changes you would recommend (for example, the mix, the selection and appointment processes, training of members)?
The current approach seems sensible. We have no recommendations for change.
32. Is there a need for the HPDT to have the capacity to deal with multi-practitioner/ team-based disciplinary matters and, if so, how should this be organised?
Yes, there is definitely a need for HPDT to deal with multi-practitioner team based disciplinary matters. At this point we have no definite ideas about how this should be managed.
33. Are the current arrangements for financing and supporting the HPDT, appropriate and what, if any, changes would you recommend (including the costs of taking cases to the tribunal and sustaining the operation of the tribunal)?
No comment.
34. Are the appeal provisions operating well and what, if any, changes would you recommend?
No comment.

35. How do you think the current number and mix of professions and authorities is operating and what, if any, changes do you think should be made?

We believe that more groups should be covered if they present any 'risk of harm' to the public. For example medical herbalists.

36. Are the provisions for adding new professions or health services working and what, if any, changes would you make?

The process of inviting comments on proposal to add new professions was an excellent opportunity to comment and learn more about their work. As far as we are aware the processes are working.

37. Are the current membership and appointment provisions working (e.g. is the size and mix right, are people with the best skills being appointed, should the power to hold elections be retained and/or used, are lay and professional members appropriately trained and supported) and what changes, if any, would you recommend?

Health practitioners were concerned about political interference when the appointment provisions in the Act was first mooted. The appointment provisions and process should be free from political interference.

38. What deletions, amendments or additions, if any, do you recommend to the list of functions – and why?

No deletions recommended.

39. How well are authorities carrying out their functions and what changes, if any, do you recommend?

We believe they are being carried out adequately.

40. Are there any specific legislative requirements that regulatory authorities are currently subject to that they should not be? Please explain.

Not that we are aware of.

41. Are there any specific legislative requirements that regulatory authorities should be subject to that they are currently not? Please explain.

As above.

42. To what extent are the current powers of the Minister of Health appropriate to the purpose and effectiveness of the Act and what changes, if any, do you recommend?

The Minister should not be able to carry out the powers listed on page 20. There should be no political interference in the appointment process.

43. What changes, if any, do you recommend to matters covered by the provisions of Part 7 of the Act?

None.

44. What changes, if any, do you recommend to specific wording in the Act in order to clarify or address technical issues not otherwise covered already?

None.

45. What, if any, other matters are you aware of in respect of the operation of the Act and what changes do you recommend?


None.

Additional Comments

There is a growth of non regulated workers being employed in the health system, for example, care givers in hospitals and aged care, non medical and nursing theatre workers providing patient care and assisting in surgical procedures. This is a large group who are not under the HPCA but for whom competence is still an important issue.

Thank you again for the opportunity to comment on this Act.

Kind Regards



Jackie Edmond
Chief Executive

