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Submission to the Ministry of Health

Review of the Health Practitioners Competence Assurance Act 2003

19th December 2007

From

**The New Zealand Association of Optometrists
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WELLINGTON**

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PREAMBLE

The NZ Association of Optometrists has generally found the HPCAA to work well in the areas of professional regulation, competence of practitioners, and membership of the regulatory authority. The inclusion of prescribing an optical appliance as a restricted task has worked well as a mechanism for protecting the public from harm but the explicit linking of the title optometrist to this task would significantly improve the ability of the public to make informed choices about eye health care.

In responding to the questions posed in the document entitled 'Review of the Health Practitioners Competence Assurance Act 2003 - Identification of issues and solutions' the NZAO has generally confined its comments to issues and perspectives of the optometry profession.

The New Zealand Association of Optometrists is an incorporated society whose objects include a commitment to high quality eye health care for all New Zealanders. The NZAO membership includes around 96% of the practising Optometrists in this country thus represents nearly all the primary providers of eye health services for New Zealand.

RESPONSES TO MINISTRY QUESTIONS:

Purpose of the Act

1. The principal purpose of the 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.

The increased emphasis on current competence for the duration of a career as a health practitioner works to ensure members of the public receive high quality services from registered health practitioners.

Unfortunately, the public are not adequately informed about the registration requirements and are ill equipped to make informed decisions as to who is competent and safe; the public is completely unprotected from unregistered and unqualified people who provide parallel services

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.

Generally, there is little evidence about how the Act is working. There has been no published analysis of the cases that have been brought to RAs as complaints or of how many have been investigated by the HDC or the Ministry of Health. There is no published information on how many cases have been left uninvestigated or unresolved because RAs felt unable to act or unable to meet the high test needed to 'prove' the provisions of the Act have been breached.

Unqualified person must not claim to be a health practitioner (section 7)

The purpose of section 7 of the Act is to provide a means of enforcing the mechanisms that have been chosen to allow the public to distinguish those persons who meet the profession's requirements for safe practice.

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*

It is asserted that one of the primary ways members of the public are able to identify between those practitioners who meet the profession's minimum standard for safe practice from those who do not is by means of the title associated with that practitioner. This is a very weak mechanism and one which is made even weaker by the poor general ability of the public to assess risk of harm.

Given the technical nature of the way that scopes, sub-scopes, and titles work there is little doubt that the public finds it difficult to know who is required to be competent in what. The NZAO foresees this problem becoming worse if the proliferation of individual scopes with a multitude of limitations occurs within a scope with a single registered title.

While the report from the Health Select Committee when the Bill was passing through the House stated that the intention of the legislation is that scopes of practice be broad (rather than narrow and prescriptive) the Act itself does not reflect this intent. Neither has the apparent ease with which unregistered providers may be able to undertake tasks within the scope of practice of a registered health provider been addressed.

Our experience of working with the public to explain and inform about the difference between an optometrist and a dispensing optician has shown that the gazetted scopes do not help much and the public does not appreciate that there is any difference between the two titles. Despite the large difference in education, clinical responsibility, scope of practice, and risk of harm the public remains blissfully ignorant of any difference in the marketplace. We often have reports from the public that they have had an eye exam by the AA! Apparently, some people think that completing a screen for visual acuity, as required for renewal of a driving license, is the same as having an eye examination. Recently, a journalist for the NZ Herald refused to use the term optometrist and insisted on describing both optometrists and dispensers as 'opticians' on the basis that the public do not understand technical terms and do not care about titles. A similar situation exists for nursing where the difference between enrolled nurses and registered nurses is completely lost on the general public.

This situation is compounded by the fact that the Act does not, in general, preclude non-registered practitioners from providing services so long as they are not breaching section 7 of the Act.

We are aware of at least one business in Christchurch which is providing services across the entirety of the scope of practice for dispensing opticians without anyone associated with the business actually being a dispensing optician and yet, apparently, they still do not meet the test of section 7.

Another compounding factor is the Ministry policies regarding enforcement which include consideration of the general rules regarding admissibility of evidence, possible defences, such as 'reasonable excuse' and additional matters such as degree of risk arising from the offence.

It appears that despite not "claiming" or "implying" they are registered health practitioners there are many people selling to the public services that fall within the scope of registered health practitioners.

Practising outside scope of practice (section 8)

Section 8 of the Act is about ensuring registered practitioners have a current practising certificate and only operate within their registered scope of practice

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

Section 8 places restrictions on registered practitioners to practise within their scope of practise, while not placing any similar restrictions on unregistered practitioners.

This seems a very clumsy mechanism for protecting the public from harm as it does not address the issue of competence when setting the limitation. Unregistered practitioners are not required to be competent at anything and, with the exception of restricted tasks, they may practice within any scope of any health practitioner. Registered health practitioners are (quite rightly) required to be competent in their scope of practice but even if competent to provide services outside that scope they may not do so despite lay people being able to do so with impunity.

To fulfil its stated purpose of protecting the public from harm the Act should ensure all health services are provided by competent practitioners.

There needs to be a mechanism to definitively stop an un-registered person from doing anything that lies within the scope of any registered health practitioner. Only health practitioners should be able to do things within those scopes and each will (by clause 8) be limited to doing things they are safe and trained to do. Section 8 needs to be amended to exclude un-registered people from the scopes of registered health practitioners.

It is the view of the NZAO that clause 8 (2) should be amended to read "No health practitioner or **other person** may perform a health service that forms part of a scope of practice of the profession....."

Restricted activities (section 9)

Section 9 sets out a means by which certain activities may be restricted to registered health practitioners. Any person is in breach of the Act if they undertake a restricted activity when they do not hold a current practising certificate with a scope of practice that includes the activity.

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?*

The provisions in section 9 do appear to be operating effectively although there may need to be more emphasis on prosecution and once a prosecution is achieved the penalties must be much higher. The current penalties seem too low to be a deterrent and the difficulties in bringing a prosecution also encourage people to take their chances. In the view of the NZAO the proceeds for the crooked individual from duping the public and prescribing spectacles and contact lenses without an appropriate diagnosis far outweigh the costs of being found out. By contrast the cost for the person who loses vision as a result of an undiagnosed glaucoma (for example) is extremely high and totally beyond restitution.

Enforcement of the Act

The Ministry of Health has undertaken the role of investigating and, on occasion, bringing prosecutions, in respect of alleged breaches of the Act.

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?*

The Ministry needs more resources for investigation and more determination in bringing prosecutions.

The law is the law and it is either obeyed or not. Actions that break the law should be treated as such. How can it be that some breaches are not important and some are? If it is not important when the law is broken and there is discretion about whether it matters or not then there does not seem much point in having a law in the first place. Of course laws of evidence must be considered but it is hard to conceive of Ministry policies that would lead to the failure to prosecute unlawful behaviour.

It is the responsibility of each regulating authority to take action when a practitioner registered with that authority acts outside his or her scope of practice. This means that if a physiotherapist (for example) engages in actions that form part of medicine and are not part of physiotherapy then the Physiotherapist Board would be responsible for investigating the breach, not the Medical Council. Therefore, the function of the regulating authorities is to keep registered practitioners inside the set scope and not to keep others out of the scope.

By contrast it will be the Ministry of Health that administers section 7 and section 9. The Ministry will firstly, use discretion in determining whether an action constitutes 'holding out' and secondly, decide whether or not to take action depending on whether there is any risk of harm and depending on priorities for action, and depending on resources available to investigate and implement action. Similarly for section 9 breaches there are a raft of "considerations" before the decision to investigate or prosecute.

Thus it seems the HPCA Act is setting up two levels of compliance. Registered persons will be tightly controlled within a particular scope regardless of any consideration of harm to the public. Unregistered people will be subject to inherently lax controls capable of interpretation and avoidance/evasion depending on the Ministry's policies and decisions regarding harm, priorities and resources at any particular time.

Scopes of Practice

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

The ability (in sections 21 and 22 of the Act) to place authorisations and conditions on a scope of practice allows an authority to recognise that, while practitioners may not be competent to work within the broader scope, they may be competent to work within a sub-section of the scope.

This is a big change from what was discussed at the time of the Select Committee report and does nothing to enable the public to make safe choices. The report from the Health Select Committee states that the intention is that scopes of practice be broad (rather than narrow and prescriptive); sections 21 and 22 of the Act itself do not reflect this intent. Clearly, someone might seek to have a narrow scope of practice as an individual so as to avoid having to maintain competence across a broad scope of practice. If these people are still able to use the title that encompasses the entire scope of practice then the public are going to be very confused and at some risk. The ability to make an appropriate choice about health care providers will become an impossibly complex task.

For the NZAO the key issue is that optometrists diagnose and prescribe so any person who is not properly qualified to diagnose and prescribe may not call themselves an optometrist. We would not wish to see any individual registered within the optometrist scope of practice who was not able to demonstrate competence in the activities related to diagnosis and prescribing.

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

The consultation process seems to operate well and has not been used to create impediments to the development of health practitioners.

The mechanism seems appropriate for extending a scope of practice to include a wider range of activities if the practitioner is appropriately qualified, and contributes to flexibility in the workforce. The process would be onerous, however, for minor changes such as the uniting of existing scopes or other small operational changes that would fall within the ambit of particular regulatory authorities.

There needs to be more discretion for the RAs to make minor within scope changes without the need for wide consultation. The need for more discretion is consistent

with the focus of RAs on keeping their own registered practitioners competent and not stopping other people from engaging in activities that fall within a scope.

Prescribing Qualifications

When prescribing qualifications, authorities must be guided by the principles set out in section 13 of the Act, which require that determinations concerning qualifications:

- must be necessary to protect members of the public
- may not unnecessarily restrict the registration of persons as health practitioners and
- may not impose undue costs on health practitioners or the public.

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.*

It is unfortunate that the prescribed qualifications for optometry have not kept pace with the scope of practice for current standards of practice.

The standard of practice for optometry is based on the clinical training set down by the University of Auckland for the Bachelor of Optometry degree. While people already registered may have had less comprehensive qualifications based on standards of practice at the time of their training, the profession as a whole has moved on. People already practising within a jurisdiction that graduated with less comprehensive training will have been influenced over time through practising within the environment. This is expressed in the level and scope of CPD for example, journals, professional and peer expectations – all of which inexorably move the standards of care in step with those expected of the new graduate. By 2010 it is estimated that more than 50% of all registered New Zealand optometrists will be designated prescribers, a proportion well in advance of Australia and the United Kingdom.

We would expect section 13 to operate in recognition of the current standards for best clinical practice of optometry which includes a differential diagnosis and prescribing of ophthalmic medicines.

Competence and recertification

Before a practitioner can renew their annual practising certificate, the authority must be satisfied that the practitioner is competent to continue practising. In order to ascertain whether or not a practitioner is competent to continue practising a registration authority may set what is known as a 'recertification programme'

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)?*

The requirements for optometrists in respect of renewing their APC include the completion of appropriate Continuing Professional Development (CPD) and in some cases a self audit against the competencies required for the scope of practice for optometry. So far these processes have seemed reasonable and there has been a very high level of compliance.

Regarding **recertification** where compliance has not been achieved or competence is in doubt the NZAO does not have sufficient experience or knowledge of how the Optometrists and Dispensing Opticians Board is proceeding at this time to make comment for this review. We are unable to make meaningful comment on questions 13 through 16.

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

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

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

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

Concerns over a practitioner's competence (section 34)

At any time, or following the raising of concerns by a colleague, the Health and Disability Commissioner, the practitioner's employer or the relevant registration authority, the authority may review the competence of a practitioner.

The NZAO believes that the Authority should investigate first to determine the need to undertake a competence review. The competence review process is costly for the Authority and disruptive and costly to the practitioner concerned so there needs to be some investigation first for the Authority to establish that competency is in doubt before embarking on a full scale competence review. At the very least the practitioner should be able to answer the charges being made against him or her and submit their own side of the story.

Section 35 states that if the registration authority has reason to believe there may be a risk of harm from the practitioner in question, they must notify the Accident Compensation Corporation, the Director-General of Health, the Health and Disability Commissioner (HDC) and the employer of the practitioner in question. If the authority believes it appropriate, they may also notify any colleagues of the practitioner in question.

This section raised two key issues: first as stated above, the Authority must engage in some process to determine there is risk of harm and secondly, the wider profession needs to be notified if a risk to harm is established. Within a community of health professionals there will always be the issue of referrals and recommendations. This is especially the case when people move from one district to another and may ask for a referral to a colleague in the new location. For optometrists, we believe the notification of colleagues extends to the entire profession and should include the professional associations to whom the public may apply for suggestions of practitioners suitable for particular clinical needs.

Section 34 of the Health and Disability Commissioner Act 1994 is also relevant because it requires the HDC to refer a complaint in part or in whole to the appropriate

registration authority if it appears from the complaint that the competence, fitness to practise or appropriateness of conduct of a health practitioner may be in doubt.

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?

In our view the Optometrists and Dispensing Opticians Board has the expertise to make those judgements but as noted above we are concerned that the Act precipitates action on the basis of suspicion and there needs to be a process of establishing the particulars before deciding there is a risk.

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

As noted above, the profession as a whole needs to be notified and in particular the professional associations who may be directing the public to practitioners who pose risk.

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?

A registration authority should exercise its power to review the competence of a health practitioner at any time it believes that competence is lacking. If the Act is a competence assurance act then the focus is, appropriately, competence. If it is intended to be an avoidance of harm act then only competencies relating to a restricted task should be necessary.

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?

We believe that there are several avenues of 'discovery' already open and in the instance of an optometrist the profession has systems in place for peer review and some level of examination of the situation prior to a suspicion being escalated to a report. In our experience of managing such a system earlier intervention with a lower threshold works well to resolve problems and remediate where necessary. In cases where there is a clear risk of harm then the ethical professions will always report to an appropriate authority.

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

This is unworkable for many employers of optometrists who are not optometrists themselves as they either do not know what constitutes fitness or they are the drivers of poor practice.

It is the view of the NZAO that where an employer of a health professional creates working conditions that prevent the delivery of best practice clinical care or provides incentives that encourage unacceptable clinical standards then they should be held accountable. Examples of this within optometry are evident in the problems rife in UK where the consumer watchdog (Which?) reported unacceptable levels of care in almost half the practices visited with key investigations not being undertaken.

Around 20% of the prescriptions issued were inaccurate and may have caused vision disturbance and headaches and in some cases the exams took only 10 minutes. The standards of care in these supermarket stores, and national and regional chains are largely directed by the employers who have considerable power to set sales targets and appointment times. The employers also control the equipment available, control the time available for investigations, and own the patient records thereby blurring the lines of clinical accountability. When the employer intercedes in the clinical process in ways such as these then they assume a level of responsibility that the HPCA Act does not appear to recognise. The Act needs mechanisms to extend accountability in the same manner as the HDC is able to hold DHBs accountable.

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.*

No Comment. The NZAO is unaware of this process being used in respect of an optometrist.

Competence programmes (section 40)

Competence programmes may be made to apply to all health practitioners, individual health practitioners or specific classes of health practitioners as the authority sees fit.

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

It appears that there are advantages from making a distinction as a competence programme may be put in place for particular reasons and in relation to particular changes in clinical best practice. A competence requirement seems to have a lower threshold and implies that not all competencies are in question. A recertification programme should be the vehicle for a wider ranging improvement in practice standards as when a person is generally unfit to practice and needs to demonstrate capacity across a wider scope.

Inability to perform required functions because of mental or physical condition

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

An authority may require a health practitioner to submit themselves for a medical examination to determine their fitness to practise.

25. *Are the interests of the public and of practitioners being balanced when dealing with fitness to practise issues? Please explain.*

No comment on balance; but wonder why the term medical examination is used. For example if blindness is a problem then an optometric exam might be appropriate and for mental illness a psychological assessment might be useful.

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.*

No comment, NZAO has had no experience of QAAs.

Professional conduct committees

PCCs allow the registration authority to examine a practitioner's practice and determine if the public is at risk of harm from that practitioner's practice.

27. *Are PCCs being used by the registration authorities you are familiar with, how often and for what reasons?*

The Optometrists and Dispensing Opticians Board is using PCC to review the practice of optometrists in response to red flags that indicate there could be a competence problem. Examples include the prolonged failure to engage in adequate levels of continuing professional development or failure to respond appropriately to all or part of a self audit review. The Board appears to be acting reasonably to protect the public from harm and the involvement of professional peers in the process is an advantage. The only concern that the profession has is the workload that the PCC process involves for members of the profession in terms of time away from practice. With a small professional community it can be hard to find sufficient numbers of willing practitioners to assist in these processes.

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?*

In our experience it has been difficult to establish at what point the suspension of an APC becomes effective. We are aware of cases where an APC has not been issued but the person is still deemed to have a current APC. We have no experience with practitioners being referred to the HPDT so are unable to comment on that process.

29. *What, if any, additional steps should be taken into account when determining to suspend an annual practising certificate?*

No comment.

Health Practitioners Disciplinary Tribunal

The HPDT is established under the Act as a single disciplinary tribunal. The functions of the HPDT are to hear charges brought by either the Director of Proceedings (an office of the HDC) or a PCC.

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?*

The costs appear to be excessive

Membership of the HPDT

The Act now provides that either the chair or one of the deputy-chairs, three professional peers of the practitioner who is the subject of the hearing, and one layperson be members of a tribunal. The Tribunal members are drawn from a panel of members including laypersons and members from each profession (section 87).

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)?*

No comment.

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?*

No

Cost of running the HPDT

The current average cost for conducting hearings is approximately \$11,000–14,000 per day.

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)?*

Linking the liability of a profession to the costs of an actual hearing is possibly reasonable but to expect Authorities to sustain the HPDT when they are not involved in hearings is not appropriate.

Part 5 of the Act: Appeals

34. *Are the appeal provisions operating well and what, if any, changes would you recommend?*

No comment

Part 6 of the Act: Structures and Administration

Concerns have been voiced about possible proliferation of regulated professions and associated regulatory authorities and whether such changes are in the best interest of the public and are necessary to achieve the purpose of the Act (ie, to protect the public).

This needs to be balanced against the fact that the public can access services from unregulated providers who have no competence standards and often no proper training. There is no evidence that having a health practitioner regulated by a dedicated registration authority diminishes the protection of the public from harm nor that a single authority for multiple professions enhances the protection

It has been pointed out that there are significant costs associated with regulation, especially when the number of practitioners covered by an authority is small.

If a profession seeks to become regulated then it should be happy to bear the costs, particularly if the act of regulation confers advantage in the health marketplace.

Multiple authorities also means that there are significantly different approaches towards assuring competence even when practitioners are providing similar services and this can give rise to problems.

Since no evidence of the "problems" is given we find it hard to imagine what these might be. Surely, it is the competence as judged by one's peers that is important not the manner in which competence is established.

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?*

The NZAO strongly supports the principle of self regulation with each profession setting the appropriate standards of care for its practitioners. This is consistent with the common law approach to duty of care and the requirement to exercise reasonable care and skill in the provision of professional advice and treatment.

From this perspective it is important that each discipline have its own regulatory authority. Each profession should operate within its own theoretical paradigm to exercise reasonable care and skill for the people who come under its care. Naturally the limits, type, and standard of that care depend on the clinical responsibilities expected of a particular profession. An approach to the lowest common denominator is not in the public's best interest.

To further condense the regulation of professional standards is not a good idea. However, there is a good case for a guidance group to be set up to advise on regulatory standards for the authorities to make administrative decisions more consistent. An example would be to standardise the conditions in which particular information is released or what processes are advisable to include when embarking on a recertification review.

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

The threshold of being necessary to protect the public from harm needs to be much more explicit and there needs to be consistency between the level of risk from already regulated professions and that posed by groups seeking regulation.

The NZAO feels strongly that existing authorities should not be forced to regulate new professions.

Although the Optometrists and Dispensing Opticians Board has shown that it is able to function in regulating two professions, the two professions covered make it difficult for single policy documents or joint regulatory processes. For example it is not appropriate for a dispensing optician to attempt judgment of an optometrist's clinical standards as the dispensing optician has not had the kind of education or training to

know what these should be. The end result has been polite co-operation but high levels of duplication of services such that there is no real economy of scale.

The use of a policy and guidelines group to do some of the more connected thinking around standardised trigger points and criteria for fair processes would be a much better way to make the admin of regulation more efficient.

Membership of authorities

Appointed versus elected members

37. *Are the current membership and appointment provisions working (eg, 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?*

While the NZAO concedes that the ability to 'elect' members of the regulatory authority is appealing, there are significant concerns that elected personnel may have a perceived duty to represent the views of those who elected them. In addition, it is noted that an election process does not always produce board members with the necessary skills required to allow the authority to undertake its duties, or the broad perspective necessary to protect the public.

Provided that the views of the profession are respected and there are mechanisms for these views to be formally sought, then the NZAO does not recommend any changes to the manner in which the professional members of the authority is appointed. The NZAO does, however, consider that for a profession with an effective Board of 5 members the addition of 3 lay people is too many. We would recommend that the Optometrists Board be limited to 5 optometrists and 2 lay people.

Functions of authorities

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

The NZAO suggests that informing the public of the services provided by the professions that are regulated should be a key function of the authorities.

This would assist the public to better understand the purpose of health professional's regulation and to make informed choices when seeking health services.

Where there is a range of professions or a range of standards covered by a single authority then this function becomes even more necessary. If a practitioner declares they are registered with the Optometrists and Dispensing Opticians Board and chooses not to use a particular title, how is the public to interpret the information and specifically how will it enable people to know what services to expect.

In eye health the public have very low levels of awareness, and are often confused, about the scope of practise of eye professionals. The qualifications and expertise of ophthalmologists, and optometrists arise from university degree courses and associated training. In contrast, "opticians" do not exist at all and "dispensing

opticians" are technicians able to manufacture devices to the prescriptions created by optometrists and ophthalmologists. These differences are significant.

Regulation by a joint authority compounds this lack of consumer knowledge. As a result there remains potential for severe outcomes in cases where a consumer may misunderstand whether their eye health has been investigated by a competent prescriber.

This difficulty may be more pronounced in the optometric field as we know consumers usually have no way to accurately know what investigations they require. The symptomless nature of the early stages of any pathology, except perhaps a perception of a 'change of vision' makes this issue ever more serious.

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

Regulation of optometrists appears to be working well and we have no substantive complaints about how the optometrist members of the authority are carrying out their functions.

Technical issues relating to authorities

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

No comment

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

The NZAO agrees that authorities should be subject to the Official Information Act 1982 to ensure more open and transparent access to information by members of the public and professions.

Powers of the Minister

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?*

These seem reasonable provided they are exercised with caution and not used for political ends

Part 7 of the Act: Miscellaneous Provisions, Consequential Amendments and Transitional Provisions

This part covers a series of small provisions along with administrative issues and consequential amendments required for the introduction of the Act.

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

No comment

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?*

No comment

Other Considerations about the Operation of the Act

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

There appears to be some conflict between sections 12 and 13 of the Act with respect to prescribing qualifications.

On the one hand section 12 allows the authority to accredit qualifications, exams, recognise practitioners who are registered with overseas bodies or recognise experience in specific areas. This is permissive and enables the authority to maintain standards of care fitting with current best clinical standards in an international sense.

However, in optometry, some commercial interests have asserted the authority is compelled to accredit and recognise under section 12 because of considerations of section 13, in an attempt to lower the standards and ease the wage bill for the employers.

An argument has been mounted that for overseas graduates with courses of optometry training that do not provide the full competence of a new NZ graduate, the costs of meeting the full competence is too high. In fact, the costs for an overseas graduate to demonstrate compliance with the New Zealand competencies for optometry is significantly less than for a New Zealand student training in New Zealand. The question then arises, why should greater consideration be given to overseas applicants who face substantially lower costs than the New Zealand graduates to demonstrate the same level of competence? The NZAO supports the emphasis of the legislation being competence and trust this will not be diminished in order to provide access for foreign practitioners with lesser or untested levels of competence. To do so would inevitably lower the standard of eye care available to the New Zealand public.

Given the scope of all new optometrist graduates as fully competent diagnosticians and prescribers of medicines, the new graduate represents the lowest possible standard of care the Board should set for the New Zealand public. For this reason any qualifications that the Optometrists and Dispensing Opticians Board recognise must meet this basic standard.

Furthermore, the Act does not provide for the Regulatory Authorities to be concerned with workforce or employment issues and it should not do so. The protection of the public and provision of best practice clinical care are the only valid concerns of the HPCA Act.

The NZAO would recommend making this distinction more explicit in the wording of the HPCA Act and would support a statement in connection with section 13 that explicitly notes that standards should not be compromised to respond to the HR desires of private sector employers.