

Review of the Health Practitioners Competence Assurance Act 2003

Identification of issues and solutions

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Introduction

The purpose of the document

Section 171 of the Health Practitioners Competence Assurance Act 2003 (the Act) requires the operation of the Act be reviewed as soon as practicable, three years following its commencement.

On 21 September 2007 Cabinet approved the terms of reference which set out the process for how the review would be conducted. A copy of the terms of reference can be found on the Ministry's website (www.moh.govt.nz).

The first stage of the review is to gather information. The Ministry is doing this in three ways:

- A survey document (this document), aimed at teasing out the substantive issues surrounding the operation of the Act at a national level. The document is aimed at a wide variety of groups working with the Act across the health sector.
- A web-based survey aimed at canvassing individual health practitioners on the operation of the Act.
- The commissioning of a literature review and report into best practice in health workforce regulation, both in the New Zealand environment and internationally.

The information collected during this phase will underpin a discussion document to be released in mid-2008. That document may make recommendations for change.

The closing date for responses to this document is Friday 21 December 2007.

Please note that:

- all correspondence and submissions on this matter may be the subject of a request under the Official Information Act 1982. If there is any part of your correspondence that you consider could properly be withheld under that Act, please include comment to that effect and give reasons why you would want it withheld.
- Although the Health Practitioners Competence Assurance Act 2003 refers to 'responsible authorities', the Ministry understands the term 'registration authority' is generally more recognised within the health and disability sector; therefore, the term 'registration authorities' has been used throughout this document.

The format of the document and request for comment

The document is organised according to the Parts of the Act. Each section contains information on that Part of the Act and questions to help prompt responses.

The list of topics and questions presented in this document are not intended to be exhaustive, or in any way restrictive.

The information presented and questions asked are to provide you with context. The Ministry recognises that many of the questions asked in this document may only be answerable by certain organisations, for example, the registration authorities or those who undertake Quality Assurance Activities; however, anyone is welcome to submit on any aspect of the Act.

The Ministry requests that where issues are identified, they are discussed briefly and, where appropriate, include proposals for change which are in keeping with the intent of the Act.

General principles to keep in mind

Set out below are some general principles that underpin the Act. These principles should be kept in mind when thinking about how the Act is operating.

- The principle 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.
- Professions need to be regulated by statute only if there is a risk of harm to the public.
- The Act contains two main levels of decision-making – Cabinet/the Minister and responsible/registration authorities.
- All decision-making on clinical and ethical standards is delegated to the registration authorities.
- Registration authorities must include lay representation.
- To assure the public, practitioners must meet qualification requirements and competence standards, set by the relevant registration authority, to enter the regulated health workforce.
- Registration authorities certify that a practitioner is qualified and competent to practise within a specified area/scope of practice.
- Practitioners must maintain that competence throughout their careers.
- Registration and maintenance of competence and fitness to practise processes should be separate from disciplinary processes.
- Processes exist for review of decisions made under the Act. These include:
 - Ministerial audit
 - the Regulations Review Committee of Parliament
 - Judicial Review.
- The Act is based on a certification regime. This means that non-regulated persons are not precluded from providing services so long as they do not:
 - use restricted titles
 - intentionally mislead the public into believing they are regulated or
 - undertake a restricted activity.

- There are elements of a licensing regime incorporated in section 9 which allows for the restriction of specific activities to registered health practitioners only. These activities must carry a risk of serious or permanent harm to warrant this level of restriction, for example, invasive surgery. Also, when registered practitioners are performing a health service in their profession they must stay within the scope of practice for which they are registered.

Part 1 of the Act: Preliminary and Key Provisions

The purpose of the Act (section 3)

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 Act (section 134) requires registration authorities' annual reports to be tabled in Parliament but, apart from requiring financial statements, the Act does not specify what reports must contain.

1. Is the Act achieving its purpose? Please explain.
2. What evidence supports your answer?
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.

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.

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.

Therefore, section 7(1) of the Act prohibits any person, other than a registered health practitioner, from using names, words, titles, initials, abbreviations, or descriptions stating or implying that they are, or are qualified to be, a health practitioner of a particular kind. For example, 'osteopath', 'midwife', 'registered nurse', etc.

Section 7(2) of the Act prohibits a person, other than a registered health practitioner, from doing anything that is calculated to suggest that they are a registered health practitioner.

Section 7(3) of the Act prohibits a person from stating that another person is a registered health practitioner of a particular kind when that person is not.

Note that, as stated above under principles that underpin the Act, 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.

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)?

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 (see Part 2 below for more about scopes of practice).

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

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.

It was envisaged that restricted activities would be necessary for activities that are likely to put patients at risk of serious or permanent harm when carried out by unqualified persons.

On 27 June 2005, the Health Practitioners Competence Assurance (Restricted Activities) Order 2005 was made by the Governor-General, pursuant to section 9 of the Act. Formal notification of the Order in Council appears at page 2396 of the *New Zealand Gazette* of 30 June 2005 (Issue No. 100, 2005). The Order in Council came into force on 1 August 2005.

There are six restricted activities:

- (a) Surgical or operative procedures below the gingival margin or the surface of the skin, mucous membranes or teeth.
- (b) Clinical procedures involved in the insertion and maintenance of fixed and removable orthodontic or oral and maxillofacial prosthetic appliances.
- (c) Prescribing of enteral or parenteral nutrition where the feed is administered through a tube into the gut or central venous catheter.
- (d) Prescribing of an ophthalmic appliance, optical appliance or ophthalmic medical device intended for remedial or cosmetic purposes or for the correction of a defect of sight.

- (e) Performing a psychosocial intervention with an expectation of treating a serious mental illness without the approval of a registered health practitioner.
- (f) Applying high velocity, low amplitude manipulative techniques to cervical spinal joints.

The criteria used to arrive at these restricted activities are set out in Appendix 6.

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?

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.

In considering whether a prosecution is appropriate, the Ministry of Health Enforcement Policy and Guidelines require consideration of the general rules regarding admissibility of evidence, possible defences, such as 'reasonable excuse' and the following matters where relevant:

- risk of death, serious injury or illness to individuals or a section of the community (ie, significant public health risk) – arising from the offence
- Ministry policy (on such offences), if any
- serious breaches of legislation of a fraudulent or misleading nature
- significant degree of culpability or repeated or persistent offending and
- potential harm to the credibility or integrity of the statutes administered by the Ministry.

The powers of the registration authorities are intended to facilitate a practitioner's return to practice (ie, there is a focus on building competence). Similarly, the Ministry has favoured non-regulatory or non-punitive solutions where appropriate.

In the instance of a first offence, the Ministry also gives consideration to the apparent intent of the offender, and the willingness of the offender to comply with legal obligations in future. In making such a decision, the Ministry is required to take into account the Crown's Prosecution Guidelines.

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?

Part 2 of the Act: Scopes of Practice and Qualifications

Before a person may practise as a registered health practitioner, they must gain registration with the appropriate responsible/registration authority. The purpose of registration and Annual Practising Certificates (APCs) is to provide the public with an assurance that a practitioner is competent by certifying that the practitioner meets the requirements to practise within a specified scope of practice. Authorities are required to prescribe scopes of practice and qualifications, which may include describing the practitioner/group of practitioners in one or more scopes of practice, prescribed qualifications and/or experience.

Scopes of practice

What was behind the concept of scopes of practice?

When Parliament's Health Select Committee (the Committee) considered the Health Practitioners Competence Assurance Bill in 2003 it became apparent that some in the health and disability sector were uncertain of how well some of the innovative provisions in the Bill would work in practice. An example was the new concept of defining scopes of practice that would set the area that a practitioner was registered to practice in.

At the time, and with the exception of the Medical Practitioners Act 1995, the 11 regulatory statutes that existed were generally considered to be out of date, inflexible, prescriptive and not meeting the needs of either consumers or the relevant health professions. The fact that the definition of profession/boundaries of practice was contained in the primary legislation meant it was extremely difficult and time consuming to update as technology, practice and service delivery evolved.

The current concept of scopes of practice seeks to address this issue by allowing each registration authority to determine what falls within the boundaries of the scope of practices that make up the profession(s) it regulates.

The ability (in sections 21 and 22 of the Act) to place authorisations and conditions on a scope of practice, is another key enabler. This 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 particularly useful in situations where a practitioner comes from overseas and may not meet the authority's registration requirements for registration in the full scope or where there is not another scope available to meet the practitioner's needs. Likewise, the ability to extend a scope of practice to include a wider range of activities if the practitioner is appropriately qualified, contributes to flexibility in the workforce.

Defining practice in scopes of practice

When the Act came into force on 18 September 2004, 99 scopes of practice were described by 15 registration authorities, describing some 22 professions (*New Zealand Gazette* of Thursday 9 September 2004 – Issue No. 120 refers).

Each authority has determined the level of generality in describing the profession in one or more scopes of practice. This requires encompassing the necessary elements to describe competence, and doing this in a way that is easy for both the profession and members of the public to understand. This is allowed for within the flexible framework of the Act.

In the past three years, since the Act came into force, more scopes of practice have been developed and gazetted (refer to Appendix 1 for a list of new and proposed scopes of practice by registration authorities).

Section 14 of the Act requires an authority to consult on proposed scopes of practice and qualifications with members of the profession(s) and other interested parties that the authority believes may be affected by the proposal.

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

Prescribing qualifications (sections 12 and 13)

When prescribing qualifications, the authorities must meet the requirements of section 12 of the Act, which allows the authority to accredit qualifications, exams, recognise practitioners who are registered with overseas bodies or recognise experience in specific areas.

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.

Part 3 of the Act: Competence, Fitness to Practise and Quality Assurance

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' (refer to Appendix 2 for examples of authority's recertification requirements).

Section 41 of the Act allows an authority to set in place recertification programmes for individuals or in respect of classes of practitioners. These programmes may consist of one or more of the following:

- a pass in an exam or assessment, or both
- completion of a period of practical training
- undertaking a course of instruction
- the examination of records by a nominated health practitioner.

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)?
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?

Fitness to practise

When there are 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.

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.

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

At the time the Act was being developed there was debate over the need to make notification by a colleague of a practitioner's competence being below a safe standard mandatory. Currently, section 34 of the Act, which sets out who may report competence/fitness to practise concerns, is permissive and does not require mandatory reporting (although many authorities consider reporting is an ethical duty and the Act states that anyone reporting in good faith will be protected from civil disciplinary proceedings relating to the reporting).

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

Following consideration by an authority of a matter referred under section 34, section 38 of the Act requires that, should the registration authority have reason to believe a practitioner fails to meet the standards for competence, the authority may restrict or stop the practitioner practising until they have met conditions imposed by the authority aimed at bringing the practitioner up to standard.

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.

Competence programmes (section 40)

For the purpose of maintaining, examining, or improving the competence of health practitioners a registration authority may, from time to time, set or recognise competence programmes.

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.

Competence programmes in the Act are very similar to the recertification programmes in section 41 (already covered above).

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

Inability to perform required functions because of mental or physical condition

The following parties are obligated to inform the registration authority should they be aware of a registered practitioner who has become unable to perform their required function because of a mental or physical condition:

- a person who is in charge of an organisation that performs a health service or
- a health practitioner or
- an employer of health practitioners or
- a medical officer of health.

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?

An authority may require a health practitioner to submit themselves for a medical examination to determine their fitness to practise. If an authority considers a practitioner is unable to fulfil their functions due to physical or mental illness, it may restrict or stop the practitioner practising until the authority is satisfied the practitioner is able to continue practising.

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

Quality assurance activities

A quality assurance activity (QAA) is undertaken to improve the practices and competence of health practitioners by assessing the health services provided by them.

The Minister of Health can declare a QAA to be 'protected' under the Act, if satisfied that it is in the public interest.

A protected QAA protects the confidentiality of information that becomes known solely as a result of the declared QAA and gives immunity from civil liability to people who carry out activities in good faith as part of the declared QAA. A protected QAA does not cover systemic investigation.

Organisations may apply to the Minister of Health to have a QAA protected. The application must set out:

- what the proposed activity will involve
- why confidentiality is in the public interest
- who the responsible person for the QAA will be.

Where a QAA has been issued, it must be reported on every six months. Within two months of the end of each reporting period, the responsible person must give each provider of a health service (who employs a person who is covered by a QAA) a report on how that QAA has been operating and what action, if any, has been taken under the QAA in question.

Within two months after the expiry of each one-year period that follows the date of a QAA notice under the Act, the person appointed as the responsible person must give the Minister a report that contains the information set out in the reports given to providers. The report may not identify any particular individual.

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.

Part 4 of the Act: Complaints and Discipline

(Refer to Appendix 5 for numbers of practitioners brought before a Professional Conduct Committee and/or the Health Practitioners Disciplinary Tribunal.)

Professional conduct committees

Submissions to the Health Committee on the Bill showed a general acceptance that the processes for complaints and discipline should be separate from the registration process. However, there was some difference of opinion on the degree of separation that is possible and desirable.

Most submissions recognised that registration authorities would need to have processes that allowed them to deal with instances of unethical conduct which breach clinical and ethical standards.

The concept of professional conduct committees (PCCs) was therefore incorporated into the Act. 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. If it is determined that there is a risk of harm, the PCC may suspend the practitioner's practice until the practitioner has completed a competence programme to the PCC's satisfaction; or refer the practitioner to the Health Practitioners Disciplinary Tribunal (HPDT).

Only the HPDT or a court may permanently strike a practitioner from the register.

27. Are PCCs being used by the registration authorities you are familiar with, how often and for what reasons?
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?
29. What, if any, additional steps should be taken into account when determining to suspend an annual practising certificate?

Health Practitioners Disciplinary Tribunal

When the Bill was enacted, there was general agreement that there should be a clear separation between the disciplinary function of the HPDT and the related registration and maintenance of competence functions of the authorities.

It was also agreed that, for the sake of consistency of application of processes and decisions and to maintain specialist knowledge, there should be one tribunal which serviced all professions. However, there was concern that this would impose undue costs on some authorities.

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?

Membership of the HPDT

Initially, the membership of the HPDT was to be either the chair, or deputy chair, two professional peers of the practitioner who was the subject of the hearing and two laypersons.

Professions argued that in order to ensure that the HPDT understood the clinical evidence being presented, the majority of the Tribunal should be constituted of professional members.

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).

Another consideration which arose at the time the Health Committee considered the Bill was the possibility of a tribunal constituted to cover practitioners from more than one profession which may arise in cases of team-based care, when more than one practitioner needs to be disciplined. The ability to constitute a single tribunal to cope with different professions could reduce the burden on witnesses and complaints. However, this issue was not investigated during the select committee process.

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)?
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?

Cost of running the HPDT

A major concern about the establishment of a single tribunal expressed by registration authorities was that they would be expected to meet costs of up to \$20,000 per day for a hearing. This cost was an estimated maximum cost for the most complex hearings, for example, involving overseas expert witnesses. The current average cost for conducting hearings is approximately \$11,000–14,000 per day.

The Act provides that each authority must make available to the HPDT an executive officer in respect of hearings brought against practitioners for whom that authority is responsible.

Some authorities have chosen to contract this requirement out to the executive officer employed by the Medical Council of New Zealand or to persons outside the registration authority structures; however, some authorities have chosen to provide their own secretariat support.

The Act also requires authorities to resource the HPDT on a hearing-by-hearing basis. However, it is not prescribed in the Act that the professions should sustain the operation of the HPDT.

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)?

Part 5 of the Act: Appeals

Part 5 of the Act sets out provisions for appeals to the courts against the decisions of a registration authority or the HPDT.

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

Part 6 of the Act: Structures and Administration

Registration authorities and registration authority structures

Number and nature of authorities and new professions

Under the Act, there were initially some 21 professions regulated by 15 separate regulatory authorities. A new authority is currently being established in respect of psychotherapy and there are a significant number of other professions that are in the process of possibly being designated as health professions.

Sections 115 and 116 of the Act set out provisions for appointing or changing authorities in respect of additional professions and the conditions for designating services as health professions.

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). 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. 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.

Other jurisdictions have addressed the issue of regulating occupational groups in various ways including having a smaller number of authorities with each covering several professions, using sub-committee structures, improving co-ordination between authorities, and requiring authorities to share functions in order to reduce costs and increase consistency of approach.

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

Membership of authorities

Appointed versus elected members

Section 120 sets out the size and make-up of registration authorities. Authorities are appointed by the Minister of Health after calling for nominations. Each registration authority must have between five and 14 members, at least two or three lay members depending on the size of the authority and a majority of health practitioners.

A concern of several professions during the select committee process was the need to ensure professional confidence in their regulatory authority. It was noted that allowing professions to elect members to the authority was one way to achieve professional buy-in.

Given the Act's focus on achieving public safety, the mix of membership anticipated by the Act should ensure authorities' members are able to make appropriate and informed decisions. Submitters generally accepted that ministerial appointments were necessary to ensure this mix. It was 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.

However, provisions were included in the Act to allow the Minister of Health, following consultation, to make regulations that allowed for the relevant authority to hold elections to elect a portion of the membership to the authority. To date, these regulation-making powers have not been used.

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?

Functions of authorities

Section 118 of the Act sets out the functions of the responsible authorities (refer to Appendix 7 for a list of responsible authorities' functions).

Functions not already discussed in detail in this paper include:

- accreditation and monitoring of educational institutions
- setting standards for clinical competence, cultural competence and ethical conduct
- promoting education and training
- promoting public awareness of the responsibilities of the authority.

38. What deletions, amendments or additions, if any, do you recommend to the list of functions – and why?
39. How well are authorities carrying out their functions and what changes, if any, do you recommend?

Technical issues relating to authorities

At the time the Act was being developed, it was considered that authorities should not be deemed Crown entities and therefore not subject to the various legislative requirements Crown entities are currently subject to, for example, the requirements of the Public Audit Act 2001, the Public Records Act 2005 and the Official Information Act 1982.

The rationale for this was that, although appointed by the Minister of Health, authorities are not funded by taxpayers nor 'controlled' by the Minister in respect of their day-to-day operation or the clinical decisions they make in respect of their professions.

However, the Act does not specifically exempt authorities from such legislative requirements and the Office of the Auditor-General has deemed authorities are still subject to the Public Audit Act 2001. The Ministry has also received some feedback since the enactment of the Health Practitioners Competence Assurance Act 2003 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.

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| <p>40. Are there any specific legislative requirements that regulatory authorities are currently subject to that they should not be? Please explain.</p> <p>41. Are there any specific legislative requirements that regulatory authorities should be subject to that they are currently not? Please explain.</p> |
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Powers of the Minister

The balance between professional and statutory regulation

At the time the Health Practitioners Competence Assurance Bill was being considered by the Health Select Committee, there was acceptance that statutory regulation is necessary where there is a risk of harm to the public. There was also support for the purpose of the Act, which is to protect the public from harm.

During the development of the Bill, a balance needed to be found between the interests of professional and consumer groups. Some professional groups expressed concern at the extent of the Minister of Health's powers. On the other hand, consumer groups were concerned that the Minister did not have sufficient powers to intervene.

The Act is based on the principle of self regulation. All decisions requiring clinical/ethical/professional knowledge are given to the registration authorities. Ministerial powers are intended to ensure public accountability to ensure that the authorities act in the interests of the public rather than the interests of the professions. The Act does not give the Minister the power to direct an authority on matters of policy, but contains a process to resolve any matters of concern about an authority's policies and practices.

The Act also gives the Minister the power to:

1. appoint the full membership of the authorities
2. audit the processes used to arrive at decisions. The power to audit includes the ability to:
 - a. appoint an independent auditor and require the authority co-operate with that person
 - b. require authorities to respond to any concerns raised as a consequence of the audit
 - c. require authorities to participate in conciliation conferences and
 - d. give directions to resolve disputes.

To date, the only powers the Minister has exercised is the power to appoint members to authorities.

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?

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?

Suggested Clarification or Improvements

A number of commentators have in the past noted a few areas and wording in the Act that could be improved in order to give greater clarity or to address technical issues.

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?

Other Considerations about the Operation of the Act

The introduction of the Act brought significant changes which may have had consequences beyond the Act's principal purpose of protecting the health and safety of members of the public. This section is intended to cover any other matters about the operation of the Act that fall outside the previous considerations of the parts of the Act.

Such matters may cover, for example:

- ways in which the Act may enhance or inhibit health service delivery
- impacts upon non-regulated practitioners or occupational groups
- effects upon the public's ability to access services
- consequences on workforce planning or development.

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

Appendix 1: Numbers of New and Proposed Scopes of Practice since 18 September 2004/05

Registration authority	Number of existing scopes	Number of new scopes	Number of proposed new scopes
Chiropractic Board	1	0	2 = Visiting Educator and Visiting Chiropractor
Dental Council	27	0	2 = Oral Surgery, Adult Care in Dental Therapy
Dietitians Board	1	0	0
Medical Council of New Zealand	39	0	0
Medical Laboratory Science Board	2	0	1 = Phlebotomist
Medical Radiation Technology Board	5	3 = Training Ultrasound, Training MRI, Training Nuclear Medicine	
Midwifery Council	1	0	1 = Midwifery Assistant
Nursing Council of New Zealand	4, (note, scope for enrolled nurse is now closed)	0	0
Occupational Therapy Board	1	0	0
Optometrists and Dispensing Optician Board	5	0	0
Osteopathy Council	2	0	0
Pharmacy Council	2	0	1 = Advanced Pharmacist
Podiatry Board	4	1 = Visiting Podiatrist Educator	0
Psychology Board	2	0	1 = Counselling Psychologist
Physiotherapy Board	3	0	0
Total	99	4	8

Appendix 2: Sample of Recertification Requirements

Medical Council

The Medical Council approves the recertification programmes offered by branch advisor body (ie, the relevant college).

Recertification programmes must include:

- A) audit, peer-review and team based assessment to verify that individual practitioners practise competently, for example:
 - external audit of procedures and
 - quality assurance activity and
 - peer review of cases, review of charts, practice visits and
 - analysis of patient outcomes
- B) educational conferences, courses and workshops.
- C) an understanding and respect of cultural competence.

Recertification programmes may include:

- self-directed learning programmes and learning diaries
- assessments that have been designed to identify learning needs, eg, of procedural skills, diagnostic skills and knowledge
- journal reading
- examining candidates for college examinations
- supervision and mentoring others
- teaching
- publication in medical journals and texts
- research
- committee meetings which have educational content, such as guideline development.

Practitioners are required to spend at least 50 hours per year on recertification activities.

Nursing Council

The following three types of evidence must be supplied to satisfy the Council's requirements.

- 1) Evidence of practice hours (a minimum of 450 hours in the last three years), verified by the employer.
 - The evidence could be a letter from the employer, or a certificate of service or a pay slip that must show the **actual hours** worked in the past year.

- Evidence of practice hours is to be signed by the employer and the name, designation, address and telephone number of the person providing the verification included.
- 2) Evidence of professional development hours (a minimum of 60 hours in the last three years), verified by the employer or nurse educator.
- This **must** include a summary of the **actual hours**, signed by the employer or educator to confirm participation.
 - This person is to include his or her name, designation, address and phone number.
 - It **must** include an explanation of what has been learnt from these activities.
- 3) Evidence of assessment of competence.
- Two of the following three methods of assessment of practice against all the competencies for the practitioner's scope of practice.
- Self assessment
 - This **must** be against **all** of the Council's competencies. The Council suggests the practitioner use the competence assessment form on their website, or a work-based form if it includes **all** the competencies.
 - The assessment is to be dated and signed by the practitioner.
 - The assessment must provide comment for each competency.
 - It **must** be signed by a nurse. That nurse is to provide an address and phone number.
 - Assessment by a senior nurse
 - This **must** be against **all** of the Nursing Council's competencies.
 - The assessment **must** provide comment for each competency.
 - The assessment is to be dated.
 - It is to be completed by a senior nurse (**not** a medical or other health practitioner).
 - That nurse **must** describe his or her position and provide an address and phone number.
 - Peer assessment or peer review
 - This **must** be against **all** of the Council's competencies.
 - The assessment **must** provide comment for each competency.
 - The assessment is to be dated.
 - It is to be completed by a nurse (**not** a medical practitioner or other health practitioner).
 - That nurse **must** describe his or her position and provide an address and phone number.

The competencies for each of the Council's scopes of practice can be found here (<http://www.nursingcouncil.org.nz/contcomp.html#Comps>).

Physiotherapy Board

A minimum of 120 hours of continuing professional development activity must be completed over three years. A minimum of 20 hours of continuing professional development must be completed in each of the three years.

The practitioner must complete at least one activity in each of the following four areas over the three-year period:

- 1) work-based learning
- 2) professional activity
- 3) formal/educational
- 4) self-directed learning.

A list of approved activities can be found here (<http://www.physioboard.org.nz/docs/phyrecertb.pdf>) on page 10.

Medical Laboratory Science Board

The practitioner must enrol in the Board's accredited Continuing Professional Development (CPD) programme offered by the New Zealand Institute of Medical Laboratory Science.

Appendix 3: Requirements that Allow/Preclude an Authority from Registering a Practitioner

Section 15

The authority may register a practitioner if the practitioner is:

- a. fit for registration in accordance with section 16; and
- b. has the qualifications that are prescribed, under section 12, for that scope of practice; and
- c. is competent to practise within that scope of practice.

Section 16

- a. He or she does not satisfy the responsible authority that he or she is able to communicate effectively for the purposes of practising within the scope of practice in respect of which the applicant seeks to be, or agrees to be, registered; or
- b. He or she does not satisfy the responsible authority that his or her ability to communicate in and comprehend English is sufficient to protect the health and safety of the public; or
- c. He or she has been convicted by any court in New Zealand or elsewhere of any offence punishable by imprisonment for a term of three months or longer, and he or she does not satisfy the responsible authority that, having regard to all the circumstances, including the time that has elapsed since the conviction, the offence does not reflect adversely on his or her fitness to practise as a health practitioner of that profession; or
- d. The responsible authority is satisfied that the applicant is unable to perform the functions required for the practice of that profession because of some mental or physical condition; or
- e. He or she is the subject of professional disciplinary proceedings in New Zealand or in another country, and the responsible authority believes on reasonable grounds that those proceedings reflect adversely on his or her fitness to practise as a health practitioner of that profession; or
- f. He or she is under investigation, in New Zealand or in another country, in respect of any matter that may be the subject of professional disciplinary proceedings, and the responsible authority believes on reasonable grounds that that investigation reflects adversely on his or her fitness to practice as a health practitioner of that profession; or
- g. He or she –
 - i. Is subject to an order of a professional disciplinary tribunal (whether in New Zealand or in another country) or to an order of an educational institution accredited by the authority or to an order of an authority or of a similar body in another country; and

- II. Does not satisfy the responsible authority that that order does not reflect adversely on his or her fitness to practise as a health practitioner of that profession; or
- h. The responsible authority has reason to believe that the applicant may endanger the health or safety of members of the public.

Appendix 4: Reasons for Not Issuing an APC

- a. The applicant has, at any time, failed to maintain the required standard of competence; or
- b. The applicant has failed to fulfil, or has failed to comply with, a condition included in the applicant's scope of practice; or
- c. The applicant has not satisfactorily completed the requirements of any competence programme that he or she has been ordered by the authority to complete; or
- d. The applicant has not held an annual practising certificate of a kind sought by the application within the three years immediately preceding the date of the application; or
- e. The applicant is unable to perform the functions required for the applicant's profession because of some mental or physical condition; or
- f. The applicant has not, within the three years immediately preceding the date of application, lawfully practised the profession to which the application relates.

Appendix 5: Numbers of Practitioners Subject to Discipline since 18 September 2004/05

Registration authority	Practitioners referred to HPDT by Professional Conduct Committee	Practitioners referred to HPDT by Health and Disability Commissioner – Director of Proceedings	Practitioners who have been the subject of Professional Conduct Committee proceedings
Chiropractic Board	0	0	2004/05 = 1 2006/07 = 1 2007/08 = 1
Dental Council	0	2004/05 = 1 2005/06 = 3	2004/05 = 1 2006/07 = 4
Dietitians Board	0	0	0
Medical Council	2004/05 = 1 2005/06 = 1 2006/07 = 3 2007/08 = 2	2004/05 = 1 2005/06 = 3 2006/07 = 10 2007/08 = 2	2005/06 = 9 2006/07 = 6 2007/08 = 15
Medical Laboratory Science Board	0	0	0
Midwifery Council	0	2006/07 = 2 2007/08 = 1	2005/06 = 1 2006/07 = 0 2007/08 = 2
Nursing Council	2005/06 = 12 2006/07 = 15 2007/08 = 5	2005/06 = 5 2006/07 = 1 2007/08 = 1	2004/05 = 17 2005/06 = 61 2006/07 = 58 2007/08 = 80
Occupational Therapy Board	0	2005/06 = 1	0
Optometrists and Dispensing Opticians Board	0	0	0
Osteopathy Council	2006/07 = 1	0	2006/07 = 1 2007/08 = 2
Pharmacy Council	2005 = 1 2006 = 1 2007 = 2	2007 = 1	2004 = 1 2005 = 3 2006 = 6 2007 = 3
Podiatry Board	0	0	0

Registration authority	Practitioners referred to HPDT by Professional Conduct Committee	Practitioners referred to HPDT by Health and Disability Commissioner – Director of Proceedings	Practitioners who have been the subject of Professional Conduct Committee proceedings
Psychology Board	2007/08 = 1	2007/08 = 1	2005/06 = 5 2006/07 = 18 2007/08 = 9
Physiotherapy Board	2006/07 = 2		2005/06 = 3 2006/07 = 1

Appendix 6: Criteria for Determining a Restricted Activity

- The risk should be one of clear serious or permanent harm.
- There should be no existing prohibitions/restrictions, such as those in the Crimes Act, Radiation Protection Act, Medicines Act.
- There should be evidence of, or proven grounds for believing there to be, a likelihood of someone other than a registered health practitioner undertaking the activity, or having access to any necessary specialised equipment with which to do so.
- The activity should be one capable of being 'done to' a person. That is, activity that does not in itself involve contact with a person (such as the diagnosis of a condition or the selection of materials for a possible device) will not in itself necessarily pose a risk of serious or permanent harm.

The proposals also need to:

- be unambiguous and capable of enforcement
- be clear to a lay person as to what is prohibited
- in some cases, be descriptive rather than use terms known to a profession but not well understood outside that profession
- avoid wording that inadvertently prohibits practitioners of a non-regulated, but established profession from carrying out activities that they are currently doing without risk of harm to the public.

Appendix 7: Functions of a Registration Authority

The functions of each authority appointed in respect of a health profession are as follows:

- a. to prescribe the qualifications required for scopes of practice within the profession, and, for that purpose, to accredit and monitor educational institutions and degrees, courses of studies, or programmes
- b. to authorise the registration of health practitioners under the Act, and to maintain registers
- c. to consider applications for annual practising certificates
- d. to review and promote the competence of health practitioners
- e. to recognise, accredit, and set programmes to ensure the ongoing competence of health practitioners
- f. to receive and act on information from health practitioners, employers, and the Health and Disability Commissioner about competence of health practitioners
- g. to notify employers, the Accident Compensation Corporation, the Director-General of Health, and the Health and Disability Commissioner that the practice of a health practitioner may pose a risk of harm to the public
- h. to consider the cases of health practitioners who may be unable to perform the functions required for the practice of the profession
- i. to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession;
- j. to liaise with other authorities appointed under the Act about matters of common interest
- k. to promote education and training in the profession
- l. to promote public awareness of the responsibilities of the authority
- m. to exercise and perform any other functions, powers and duties that are conferred or imposed on it by or under the Act or any other enactment.