Analysis of Responses to Ministry of Health Survey Document – *Review of the Health Practitioners Competence Assurance Act 2003: Identification of issues and proposed solutions*

Ministry of Health. 2008. *Analysis of Responses to Ministry of Health Survey Document – Review of the Health Practitioners Competence Assurance Act 2003: Identification of issues and proposed solutions*. Wellington: Ministry of Health.

Published in March 2008 by the
Ministry of Health
PO Box 5013, Wellington, New Zealand

ISBN 978-0-478-31727-5 (online)
HP 4560

This document is available on the Ministry of Health website:
http://www.moh.govt.nz

Contents

Introduction 1

Part 1 of the Act: Preliminary and Key Provisions 2

Part 2 of the Act: Scopes of Practice and Qualifications 3

Part 3 of the Act: Competence, Fitness to Practise and Quality Assurance 5

Part 4 of the Act: Complaints and Discipline 7

Part 5 of the Act: Appeals 8

Part 6 of the Act: Structures and Administration 9

- Technical issues relating to authorities and the HPDT 10
- Powers of the Minister of Health 11

Part 7 of the Act: Miscellaneous Provisions, Consequential Amendments and Transitional Provisions 12

Suggested Clarification or Improvements 13

Other Considerations about the Operation of the Act 14

Conclusions 15

Appendices

- Appendix 1: Detailed Comments from Respondents 16
- Appendix 2: Respondents to the Survey 52
- Appendix 3: List of Abbreviations 55

Introduction

The purpose of the Health Practitioners Competence Assurance Act 2003 (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'.

Section 171 of the Act requires the operation of the Act to be reviewed as soon as practicable once three years have passed since its commencement.

On 11 October 2007 the Ministry of Health initiated the review when it circulated the survey document, *Review of the Health Practitioners Competence Assurance Act 2003: Identification of issues and proposed solutions* (the document).

The document presented information on the Act and asked respondents to consider how the operation of the Act had impacted on the health sector. Respondents were asked to identify operational aspects of the Act that were working well and those that needed improvement. Where operational issues were raised, respondents were asked to make suggestions on how these issues could be addressed.

The following analysis draws together the results of the Ministry's survey, dealing with responses to each part of the Act in turn. Appendix 1 sets out comments from respondents in more detail. The respondents to the survey are listed in Appendix 2. Appendix 3 explains the various abbreviations used throughout this document.

Part 1 of the Act: Preliminary and Key Provisions

Among respondents to the survey, there is a strong feeling that the Act is likely to be achieving its purpose of protecting the public through ensuring the competence of health practitioners. However, evidence to substantiate this anecdotal view is lacking. Many respondents commented that the timeframe between the implementation of the Act and the review was simply not long enough to judge whether the Act is achieving its purpose. Several respondents suggested that research be commissioned into the Act's impact on practitioner competence and public safety.

It was also emphasised that there is a lack of information on the purpose of the Act and its mechanisms. Several respondents suggested an education campaign is needed for the benefit of the public, practitioners and employers.

A number of respondents felt that the responsibilities of those subject to the Act (practitioners, responsible authorities (RAs), employers, the Ministry of Health, etc) are not clearly delineated. This lack of clarity is hindering the development of relationships among those who have significant responsibilities under the Act and thus, in part, is contributing to inefficiencies in the operation of the Act.

Although some commented that restriction of title is not a good way of enabling the public to distinguish between practitioners who are competent and those who are not, there was a stronger feeling that this mechanism is appropriate. However, it was felt that the public and often practitioners and employers do not have a good understanding of the certification system that underpins the Act and what it means for them.

Some respondents felt the Act is not truly achieving its goal due to the perception that, while regulated practitioners cannot work outside their scope of practice, unregulated practitioners are able to work in any scope with impunity. Respondents felt that if the Act is to truly achieve its goal, then unregistered practitioners should not be able to undertake any work that is included in the scopes of regulated practitioners.

Some respondents suggested that the list of restricted activities should be expanded to include a range of other activities, including the practice of medicine, anaesthesia and prescribing of contact lenses to name a few.

There was strong support for revisiting the restricted activity relating to performing a psychosocial intervention and for addressing its impacts on unregistered practitioners, such as social workers.

Views on the Ministry of Health's approach to enforcing the Act were split between approval and disapproval. Although it is clear all RAs, who responded to the survey, did not approve of the Ministry's approach, many individual practitioners and other groups believed the Ministry is enforcing the Act appropriately. However, there was a call for the Ministry to publicise its enforcement activities more widely.

Part 2 of the Act: Scopes of Practice and Qualifications

Generally, respondents to the survey felt that scopes of practice are an appropriate mechanism to describe professions and ensure flexibility. However, a strong view expressed was that, for many professions, the scopes do not describe the profession accurately, or they describe the profession in such a technical way as to be uninformative or meaningless to those outside of the profession, such as the public or employers.

Another concern was the seemingly cursory engagement between RAs when developing standards to underpin overlaps in scopes of practice. A lack of jointly developed standards may be leading to inconsistency in applying modalities of treatment; for example, in prescribing medicines.

Several respondents suggested that a number of scopes reflect traditional professional paradigms rather than the service environment. However, others suggested that it is inappropriate for scopes to reflect the service environment as the intent of the Act is to protect the public, not to facilitate workforce need. It was felt that bowing to employer pressure to create a more generic workforce, in order to meet workforce needs, would blur professional boundaries; therefore, it would make it more difficult to ensure public safety.

A strong view was expressed over the lack of consultation in respect of developing scopes of practice. This view was reflected less by the regulated professions than by service providers and other professions who may have an interest in the scopes and commensurate registration and recertification pathways.

A requirement that scopes of practice be regularly reviewed was supported.

Some respondents felt that those who no longer practise may still have much to offer in an advisory capacity and that scopes should be developed to reflect this potential resource.

One concern raised was that RAs give insufficient consideration to section 13 of the Act, with a consequence that the costs of compliance with RA requirements may be unnecessarily high.

The provisions in sections 21 and 22 of the Act, which allow for conditions to be placed on practice, were seen as potentially highly enabling. Equally, though, there was concern that many RAs were not using these provisions, possibly due to the administrative burden they pose. In addition, where these provisions were being used, they were often used as a means of restricting practice rather than enabling it. Greater use of these provisions to enable overseas practitioners to practise in New Zealand was seen as a matter for all RAs to consider more closely.

In general, professional bodies regarded the qualifications and standards of practice required by RAs as appropriate. However, many individual practitioners who responded suggested that the requirements set by many RAs are overly onerous, and only serve to protect or enhance the standing of the profession. It was felt by many that often these requirements act as a barrier to overseas practitioners, practitioners who wish to work part time, practitioners who wish to re-enter the profession, and practitioners who would otherwise remain in the profession but, due to the requirements, opt to retire.

Some respondents felt that many qualifications are being driven by education providers rather than being developed to meet the needs of practitioners. Some identified a need to reduce the focus on university-based education and to give greater recognition to practical experience and other forms of competence assessment.

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

Respondents to the survey generally believed that recertification is of benefit.

Some respondents felt that while recertification and competence programmes differ from each other and both have their place, there is some confusion in the health sector as to how they are different and how they should be used. Some asked for clarification of the differences between recertification and competence programmes, as well as greater consistency in their application.

A strong view expressed was that recertification should be mandatory. However, this initiative would entail cost considerations for those professions with a significant proportion of rural or part-time practitioners and for those professions with relatively few practitioners.

Concerns were raised regarding the inconsistent ways in which RAs develop and monitor recertification requirements. Some respondents felt that this inconsistency makes it difficult to gather comparable data on the effectiveness of recertification. If the benefits of the Act are to be measured, RAs need, where possible, to become more consistent – individually and collectively – in developing and monitoring recertification requirements.

Many felt that information collected by RAs in respect of competence, fitness to practice and recertification should also be made publicly available.

Other concerns related to the costs associated with meeting recertification requirements for registration, particularly for practitioners in rural areas or those working part time.

Some respondents felt that a focus on rigid university- or course-based registration and recertification programmes is clearly increasing costs, and is not necessarily maintaining or improving competence. Many suggested that more meaningful measures of ensuring competence, such as greater recognition of experience when registering, or use of peer review or onsite assessments when assessing competence, would be more appropriate and cost-effective.

Respondents also noted that the lack of accreditation of employment-based programmes is having an impact on service provision, as ensuring staff competence generally comes at a cost to the employer and takes practitioners away from the patient. In the view of some respondents, ensuring competence closer to the point where the practitioner interacts with the patient is more likely to secure ongoing competence and minimise the impact of the process on the employer and the patient.

Some respondents suggested that employers are using notifications of competence issues and inability to practise as a substitute for performance management. Others suggested that it is appropriate for employers to have systems in place to address these concerns, rather than referring every instance to an RA. There was a clear message that employers and practitioners need guidance as to when concerns over competence and fitness to practise should be reported to the relevant RA. Mechanisms should be put in place so these issues may be dealt with at the appropriate level. Where concerns are referred to an RA, more consistent and expedient processes are needed to address the practitioner's competence or limit/stop them from practising.

Some supported the idea of compulsory reporting of competence concerns. In general, however, respondents opposed such reporting by practitioners due to the undesirable workplace culture that it might foster.

Many respondents suggested increasing public notification around competence and fitness to practise issues. The reasons for this measure would be to ensure that patients can be fully informed of the practising status of their practitioner, practitioners can be confident of patient's safety when making referrals and employers can be confident of the safety of practitioners when hiring. As some respondents saw it, it is not always easy to access information relating to the competence and fitness to practise of practitioners.

Some felt that section 35 notifications happen too slowly. As a result, the public is put at greater risk.

It is also not clear what happens to the information made available to agencies listed in the Act when a section 35 notification is made.

Some respondents suggested that RAs and the Ministry of Health develop guidelines to ensure consistency in the notification of harm, activation of competence reviews and level constitution of competence programmes, information reported on publicly and how that information is made public.

Some thought that protected quality assurance activities (PQAAs) limit the public's rightful access to information. However, respondents generally agreed that PQAAs are an important safety and educational tool. It was felt that this section of the Act needs to be reconsidered or clarified to deal with issues such as the technical aspects of obtaining PQAAs, the reporting requirements, paucity of enforcement, and legal concerns around serious incidents. Additionally, the adoption of PQAAs has not been consistent across all practitioner groups because the Act introduced them to all practitioners **except** doctors, for whom PQAAs were already established under earlier legislation. The role of PQAAs as a protective measure across practitioners' activities is of benefit, but is yet to be fully realised.

Part 4 of the Act: Complaints and Discipline

The Act provides for the ability to discipline practitioners or address their competence. However, where a competence issue does not exist, the penalties provided for are overly punitive. A range of penalties at the lower end, such as the ability to impose fines, is needed.

Respondents to the survey felt that although professional conduct committees (PCCs) are useful and generally arrive at the right result, they often get bogged down in legalistic process and can be time-consuming and expensive. As a result, the practitioner can still practise while under investigation and, in the interim, public safety is not ensured and the practitioner has no certainty in respect of their future. Some respondents felt that RAs should be given more discretion and other tools to deal with less serious matters.

Some suggested interim suspensions of annual practising certificates (APCs) should be reserved for the most serious cases heard by a PCC. However, others suggested lowering the threshold at which a PCC could be activated, and providing the RAs with the ability to impose interim suspensions before the practitioner has had a chance to be heard.

Respondents were unanimous in their view that a single Health Practitioners Disciplinary Tribunal (HPDT) is appropriate.

The ability for the HPDT to hear multidisciplinary cases had strong but not unanimous support.

The strength of opinion among respondents was in favour of a single secretariat to support the HPDT. However, opinions were divided as to whether the secretariat should be funded by the professions, the Government or jointly.

While some thought there should be more lay representation on the HPDT, others wondered about the usefulness of having any lay representatives at all. Respondents clearly agreed, however, that it is important to select health practitioners to sit on the HPDT. They felt that, to date, the process of appointing health practitioners to the HPDT has not been transparent or robust and that this area needs to be addressed.

Part 5 of the Act: Appeals

There were only two comments on provisions relating to appeals. One stated that to take appeals is quite costly, while the other referred to the inconsistent application of name suppression when applied under the Act as opposed to through the courts.

Part 6 of the Act: Structures and Administration

In general, respondents to the survey believed that evidence is lacking as to whether it is better to have one or several authorities and supporting secretariats regulating professions under the Act. Equally, though, they felt that a proliferation of authorities and secretariats, particularly small ones, will increase costs and decrease efficiencies and co-ordination on common issues.

Section 3(2)(a) states that the Act seeks to provide ‘for a consistent accountability regime for all health professions’. Respondents felt, however, that this consistency has not been achieved. Many believed that the existing inconsistencies are in part due to the number of current RAs and the differing manner in which individual RAs have approached their responsibilities under the Act. Examples of inconsistencies that were given included recertification and competence review processes, registration systems and processes, information release standards, and processes and engagement with employers, practitioners and other stakeholders.

As a result of the inconsistencies in the regime, the cost of compliance for the professions under the Act can vary dramatically, as can the cost of running an RA under the Act. Respondents also felt that the number of RAs in a small country like New Zealand is not efficient and that the potential for more RAs may increase compliance costs even further.

A clear view expressed was that there is a need for a more consistent and cost-effective approach to regulation, so that existing and new professions can be regulated more efficiently and consistently. Achieving this approach should be balanced with the need to maintain professional autonomy.

In respect of regulating currently unregulated professions, the strong view put forward was that the threshold for regulating should be raised. Assessment should be based on evidence of harm, frequency of harm and the impact on public safety from regulation. These factors should be considered in tandem with a cost–benefit analysis and prioritisation of proposals for regulation against risk of harm. Critical mass should be considered when establishing stand-alone authorities.

The idea of establishing trans-Tasman regulators, given the already close links between New Zealand and Australian colleges and RAs, was also floated.

Governance arrangements for RAs were one area that drew considerable comment from respondents. While many respondents strongly supported the status quo of fully appointed RAs, many other respondents strongly supported the possibility of including at least some elected members.

However, a predominant theme arose from both those in support of elected members and those in support of the status quo. Namely, there was widespread recognition of the need for openness and transparency, as well as engagement with and accountability to the profession the RA regulates and the public the RAs are established to serve.

Those in support of fully appointed RAs expressed concerns that elected members may feel a duty to represent the views of those who elected them. Additionally, it is not guaranteed that an election will produce an RA membership with the skills necessary to undertake the RA's functions or with the broad perspective necessary to protect the public.

Those in support of including elected members, on the other hand, felt that the current process for appointing members is not clear, open or transparent. For this reason, they felt that there is significant potential for political interference and no means of securing professional confidence in the RAs. Elections were seen as the easiest means of addressing this concern.

In terms of the RAs' performance in discharging their functions, respondents generally felt that they have done well in coming to terms with and implementing their obligations under the Act since its implementation. Some particular issues noted related to the seemingly inconsistent approach of the RAs in operationalising the same functions. Other concerns were a lack of openness and transparency in terms of releasing information to do with competence and fitness to practise, and of developing scopes of practice, accrediting qualifications, and so on.

Technical issues relating to authorities and the HPDT

Another suggestion continues with the theme of ensuring greater openness, transparency, engagement and accountability in the way the RAs discharge their functions. Specifically, some respondents have suggested making the RAs subject to the Official Information Act 1982 and the Ombudsmen Act 1975.

RAs noted the costly requirements to which they are subjected as a consequence of being considered Crown Entities under the Crown Entities Act 2004. As RAs are not funded with public money, it was requested that they be exempt from the Crown Entities Act.

Some respondents proposed a range of relatively minor amendments. These amendments centred on the RAs' ability to speed up competence reviews and disciplinary processes.

Comments were also received regarding the threshold for notification from practitioners, employers and RAs to parties listed in the Act. Some expressed the view that the thresholds are too high, while others stated that they are too low. The ability for greater discretion for these parties was requested.

Some respondents commented on the various tests that must be applied in respect of 'risk of harm', 'serious risk of harm' and 'risk of serious harm'. As these terms differ in meaning, more consistency in the way the tests are applied was requested.

Requested amendments around scopes of practice related primarily to an RA's ability to place conditions on practice that expand the practitioner's scope. At present, many RAs are interpreting sections 21 and 22 of the Act as allowing only the reduction of a practitioner's scope of practice.

Section 158, which relates to the Trans-Tasman Mutual Recognition Act 1997 (TTMRA), received the most comments of any section in Part 6. Respondents expressed concern that substandard practitioners are able to enter and gain registration in New Zealand through Australia. A residency requirement has been suggested as a possible solution.

Powers of the Minister of Health

Some respondents suggested reducing the Minister of Health's powers to avoid subjecting the RAs to political interference. Others, in contrast, suggested increasing the Minister's powers as a way of ensuring the RAs are being run efficiently and effectively and are taking account of views expressed by interested and affected parties.

Additionally, some respondents suggested that the professions, individual practitioners and the public do not clearly understand the nature of the Minister's powers, and that their nature should be clarified.

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

The Trans-Tasman Mutual Recognition Act 1997 received considerable comment in submissions regarding Part 7 of the Act. Respondents made suggestions as to how to amend it to reduce inflows of incompetent practitioners into New Zealand, and to reduce outflows of competent practitioners to Australia. For both of these objectives, the amendments proposed involved imposing residency requirements.

Another suggestion was to put in place a requirement for reviewing the Health Practitioners Competence Assurance Act 2003 every three to five years.

Suggested Clarification or Improvements

Comments made on clarifications and improvements related primarily to the necessity for continuity within the legislation, and between the Act and other pieces of related legislation.

Clarification of various concepts within the Act, such as ‘competence’ and ‘recertification’, was also suggested.

Other Considerations about the Operation of the Act

In regard to other considerations, the primary concerns related to the Act's impact on the health workforce. Some suggested that the Act should require RAs to give consideration to the health workforce when discharging their duties. Others, by contrast, thought the Act should be focused only on public safety, with workforce considerations having no influence on RAs' determinations around standards of clinical competence.

A strongly supported suggestion was the need for greater awareness of the Act and its implications/requirements among professions, employers, practitioners and the public. Some respondents suggested developing operational guidelines to delineate the responsibilities of various parties, and running an education campaign to raise public awareness.

Conclusions

Generally, respondents to this survey saw the Health Practitioners Competence Assurance Act 2003 as establishing an improved regime relative to that which operated under the previous multitude of Acts that regulated professions prior to 2004.

All the core principles that underpin the Act were seen as positive developments. These principles include: scopes of practice; the introduction of a mechanism to allow practitioners to maintain and demonstrate competence for the life of their practice; the move towards addressing competence shortfalls as opposed to simply providing for punitive action; and the separation of discipline from regulation.

However, respondents identified some issues in respect of the way in which these mechanisms and the requirements of the Act in general are being operationalised. These issues can be summarised as follows.

- **Information**: There is not good information on the effectiveness of the Act and, in particular, on the effectiveness of recertification and quality assurance activities.
- **Understanding**: There is poor understanding of the Act, its implications for those subject to it, and the responsibilities of individuals/organisations under it.
- **Working together**: There is much disconnectedness among those subject to the Act, particularly with respect to the relationships between RAs and service providers.
- **Consistency**: There seems to be significant policy inconsistency and systems duplication in how RAs and service providers are operationalising the Act. It was felt that these factors were increasing costs.

Appendix 1: Detailed Comments from Respondents

Introduction to appendix

The following analysis is in most instances not a verbatim quote of responses to the Survey document. Respondents have been grouped together on the basis of their comments aligning with a more generic statement which represents a range of similar views.

The numbers at the end of each statement are decoded in Appendix 2 (list of respondents).

Part 1 of the Act: Preliminary and key provisions

The purpose of the Act (section 3)

The Act seems to be achieving its purpose. The evidence exists in the processes set in place by each RA in order to meet the provisions of the Act. Although risk of harm to the public cannot be eliminated, the processes have enabled a degree of clarity by establishing scopes of practice and restricted activities, ensuring initial and ongoing competence of practitioners, and providing mechanisms to deal with complaints and incompetent or unfit practitioners. 4, 5, 8, 10, 15, 16, 17, 18, 19, 20, 21, 31, 32, 38, 40, 41, 42, 43, 45, 47, 55, 59, 61, 62, 65, 69, 71, 72, 74, 76, 80, 82, 85, 92, 95, 96, 98, 102

The Act does not seem to be achieving its purpose. This is highlighted by the inability of some RAs to define scopes that meet the needs of either consumers or the profession; for example, counselling psychology. 84, 113

Possibly, but it is too early to say if the Act is working. Information around the effectiveness of the Act is not well reported. Reporting requirements, for example, more than just financial statements required in financial reports, need to be developed. In addition, there is a need for an independent audit agency (equivalent to the Education Review Office in the education sector) and perhaps research on the effectiveness of the Act. Ensuring consistency in the information produced RAs is also crucial. 1, 24, 28, 29, 33, 37, 40, 46, 50, 51, 52, 53, 55, 58, 64, 65, 70, 73, 77, 79, 87, 90, 104, 105, 106, 107, 108

The availability of information to the public and the professions has increased since the establishment of the Act. However, it is difficult for the public, employers and often practitioners to find that information as it is available through many and varying means, and can be obscure and confusing in nature. 1, 5, 37, 87, 96, 107

Differing interpretations of provisions of the Act are causing confusion. 4, 10, 28, 39, 61, 70, 71

The public is unprotected from individuals who provide parallel services to those provided by registered health practitioners. 1, 114

The Act has increased the number of midwives engaging in recertification, and made it easier to collect information on the midwifery workforce (which was previously partly subsumed in information on the nursing workforce). 15

There is confusion between the requirements imposed by the Act and those imposed by employers. Guidance needs to be developed to clarify the responsibilities of each party in terms of the Act. Another option may be to have a member of a service provider organisation appointed to each RA. 17, 58, 82, 113

No, some RAs have implemented the Act restrictively in respect of registering overseas trained practitioners. 94, 113

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

Restriction of title is not a good way of allowing the public to distinguish between those practitioners who are competent to practise and those who are not. There are many cases where unregistered practitioners simply do not use a restricted title but continue to provide the potentially harmful services that led to the profession's regulation in the first place. The Ministry of Health seems unable to prosecute these people due to the obscure wording of section 7, and thus the difficulty in operationalising this section through to a successful prosecution. Section 7 should capture people whose actions 'taken as a whole' lead someone reasonably to believe that the person is registered. 1, 29, 53, 81, 108, 114

There is confusion in interpreting this section, in respect of what people can call themselves and what they cannot. There are many professionally used titles that are not registered by RAs. A catch-all phrase such as 'implying to be a qualified health practitioner' may be useful. 10, 37, 43, 44, 51, 52, 71

The emergence of health care assistants within the sector is of concern as these are unregulated practitioners who, due to financial and workforce constraints, are often asked to perform tasks that would usually be performed by a registered practitioner due to the potential risk of harm. 15, 19, 37, 50

Restricting titles seems to be working well, and people seem to be aware that they cannot use a registered title unless they are registered. However, the public is not so well-informed. 18, 19, 21, 24, 36, 37, 46, 47, 55, 58, 62, 65, 69, 70, 73, 74, 95, 99, 100

Some people hold the same qualifications as registered practitioners but have not registered. These people and their employers are interpreting the provisions in section 7 as meaning the practitioner cannot use those qualifications. 35

That the title 'nurse' is not protected, unless it is included in the titles 'registered/enrolled nurse' or 'nurse assistant/practitioner', is of concern, represents a danger to the public and is contrary to the nature of the Act. 36

Some unregulated practitioners, for example, naturopaths and nutritionalists, are undermining advice given by registered practitioners. 85, 101

The penalties associated with a breach of section 7 need to be higher. 98

Practising outside scope of practice (section 8)

Where professions overlap, standards that underpin their overlapping scopes are often not aligned between RAs; for example, when determining best practice in prescribing medicine. This lack of alignment also exists within professions, such as psychology. In addition, practitioners cannot move easily between areas of practice and, if necessary, between RAs as their career develops. It can also be difficult for practitioners to know when they are and when they are not working outside their scope. 5, 16, 18, 19, 23, 33, 37, 64, 95, 102

There are instances where practitioners are known to be acting outside their scope, but nothing is done. 10

Some employers are pressuring staff to work outside their scope of practice due to workforce shortages. It is recommended that RAs give better information to employers and monitor them more closely. 21, 22, 52, 53, 113

Some practitioners use techniques (under the guise of a registered health practitioner) that the RA has not been approved as part of their scope. As these techniques do not form part of another registered scope of practice, it is unclear whether a practitioner could be considered to be working outside their scope. 29

Generally this section is working. However, there are some issues in smaller centres. 74, 95, 114

Section 8(2) relates only to practitioners performing a service within their scope that is not allowed. It is not transparent for the public because there is a lack of awareness of scopes, and generally the public assumes practitioners carrying out procedures are qualified. 81

Section 8(3)(b) should be amended to make it clear that 'training' must be approved by the RA. 81

Generally this section is working well. However, procedures should be developed and publicised regarding how practitioners are dealt with when found to be working outside their scope. 104

Restricted activities (section 9)

Registered practitioners are not allowed to work outside their scope of practice, even if competent to do so. Unregistered health practitioners may work in any scope with impunity. If the Act is truly to achieve its goal of protecting the public, unregistered practitioners should not be able to undertake activities that are included in the scope of a registered health practitioner. 1, 4, 10, 37, 71, 84, 90, 108, 114

These provisions seem to be working well. However, the penalties associated with a breach of section 9 need to be higher as they currently do not pose much of a deterrent. 1, 4, 70

The list of restricted activities should be expanded so that it is comprehensive. It should include: non-prescription contact lenses; tooth bleaching or all activities that take place in the mouth; planning to provide care to woman and babies during childbirth; aspects of childbirth; diagnosis of psychiatric disorders; the practice of medicine; the practice of anaesthesia; the provision of nutritional advice to unwell individuals or the prescribing of medical nutritional therapy; manipulation of the spine (not just the cervical spine); and the use of X-rays. 1, 4, 8, 11, 15, 24, 50, 53, 69, 81, 92, 95, 95, 99, 105

The restricted activity around psychosocial interventions is necessary, but is ambiguous and needs clarifying as to at what level a psychosocial intervention becomes 'serious'. The activity also restricts unregulated professions, such as social workers and addiction counsellors, and this aspect of restriction needs to be addressed. 17, 20, 24, 27,34, 37, 47, 61, 64, 65, 67, 68, 75, 88, 89, 91, 97, 98

It is not immediately evident to the public or practitioners which practitioners may perform which restricted activities. 29

Restricted activities should be dispensed with or should reflect activities that carry a serious risk of permanent harm, and might reasonably be expected to be carried out by members of the public. The list does not currently reflect this principle. 33, 37

This list should be reviewed regularly. 46, 73

Concern surrounds less qualified and experienced individuals taking on roles that are suitable only for registered practitioners. The Ministry of Health does not always understand the specialist nature of many activities carried out by registered professionals, and, at times, seems to encourage those less qualified to perform actions that are highly dangerous, and for which they are not qualified. For example, anaesthetic technicians, despite being unregistered, may perform 'invasive procedures in the mouth and under the skin through the insertion of cannula and intravenous lines'. This encouragement contradicts the purpose of the Act. 50

Section 9(5) should limit training to those approved by the RA. 81

The wording of the current restricted activities is ambiguous. 95, 104, 108

Enforcement of the Act

The law is the law. Prosecutions of unregistered practitioners should not be subject to Ministry of Health policies and availability of resources. 1

There is a lot of ambiguity as to when the use of a title causes a person to be in breach of the Act. It is unclear which titles constitute breaching the Act and which do not. A list of restricted titles should be produced. 4, 51, 79

It is important that the Ministry and RAs work together to actively seek to enforce the Act. This approach is of particular importance in non-English speaking communities where foreign practitioners may be operating outside the law. 5, 11, 105

There is a need to clarify the respective roles of the Ministry and RAs in respect of enforcing sections 7, 8 and 9. 7, 99

The Ministry's approach seems to be working. 18, 19, 21, 22, 38, 40, 58, 65, 70

The Ministry's reluctance to employ section 7 is placing the public at risk. The Ministry needs to meaningfully assert its responsibilities in respect of enforcing the Act, and think about what changes need to be made to facilitate this. One such change is the need to consider when a prosecution will provide an educational opportunity for other practitioners that may lead to an overall improvement in practice. Increasing RAs' powers around section 7 and enabling higher penalties are other possibilities. 24, 43, 64, 81, 96, 99, 106, 107, 114

There is concern that the Ministry has not enforced section 7 of the Act; the Medical Council of New Zealand no longer forwards names of doctors practising without an APC as no action is taken. 43

Where the Ministry has issued warnings to unregistered practitioners, there is no evidence of follow-up to ensure they comply. 29

The Ministry's policy should be more widely advertised. 46

The Ministry should report on prosecutions taken under the Act as an educational tool to allow people to understand what they cannot do. 90, 96

Part 2 of the Act: Scopes of practice and qualifications

Scopes of practice

Scopes seem to be working in most instances. However, due to the siloed nature of the RAs, scopes of practice do not always reflect the multidisciplinary nature of service delivery in many areas of the health workforce. Additionally, public confusion around what a registered practitioner is and is not competent to do grows if the risk of a proliferation of scopes of practice and restrictions/authorisations eventuates; the nature of a scope of practice is generally poorly understood. It is not transparent that RAs are always acting in the public's best interests, and not in those of the profession (or subgroups within a profession). As a result, scopes of practice do not always reflect service need or current professional practice. The way that scopes are described needs to be balanced in terms of: reflecting the skills necessary to ensure public safety; being meaningful to the public and profession; being restrictive enough to ensure a practitioner is working only within their sphere of competence; and being broad enough not to restrict service delivery. Examples of where scopes do not reflect these principles are adult care in dental therapy, dental technology, counselling psychology and breast cancer screening. RAs should be mindful that, increasingly, the overlap of professions is a necessity; therefore, no one profession owns a skill or activity in and of

itself. Also, fluidity of scopes of practice is important as knowledge development grows exponentially. As such, no one professional is able to be competent in all aspects of their scope of practice. Therefore, RAs should give greater consideration to ways of jointly developing scopes of practice. 1, 4, 5, 8, 9, 10, 15, 17, 18, 23, 24, 29, 31, 32, 37, 38, 40, 43, 50, 51, 52, 55, 58, 62, 64, 65, 69, 70, 71, 73, 75, 76, 77, 79, 82, 84, 85, 87, 92, 95, 98, 102, 103, 104, 107, 198

The ability to place conditions and limits on APCs allows for public safety without removing the right of the practitioner to practise. This approach means that educational processes can be put in place to assist the practitioner. It is more effective than a punitive approach. It is also very useful in enabling overseas practitioners to gain registration. However, some RAs are not using this mechanism in an enabling way. In addition, some employers are confused as to what practitioners can and cannot do with conditions; for example, as to whether a practitioner registered in a broad scope is or is not competent to work in a specialist area. It is necessary to strengthen monitoring of practitioners to ensure they are working within their scope, and to more widely disseminate information about who is allowed to carry out what activities. 15, 19, 21, 24, 32, 38, 40, 43, 50, 51, 52, 53, 62, 70, 71, 79, 82, 85, 87, 90, 92, 94, 95, 104, 105, 106

The consultation process around developing scopes works well. However, RAs should have more discretion to make minor adjustments to scopes without needing to engage in a full consultation process. 1

Consultation requirements in the Act need to be strengthened. Often practitioners and the public are unaware when new scopes are being developed or existing scopes are changed. Additionally, allied health organisations and non-government organisations (NGOs) tend to get left out of conversations, with the result that scopes are developed for the District Health Board (DHB) environment, in which others then have to try to fit. Finally, RAs' links with educational institutions are not as strong as they could be. 2, 3, 4, 8, 9, 10, 11, 17, 23, 29, 33, 36, 37, 65, 69, 82, 85, 95, 95, 100, 104, 106, 107

The choice of title associated with a scope of practice is significant, particularly where a single scope exists to cover a range of practitioners working in different fields of the same profession, for example, the different fields of psychology. It is possible that the title of the scope of practice may inadvertently accord more standing to one field of practice than another. 3, 37, 64, 75

The powers under sections 21 and 22 are often used to restrict a practitioner's practice when a practitioner has not met recertification requirements, or when competence issues have been raised. Many RAs are not using these same powers to allow overseas practitioners, who may not meet the requirements for registration in a full scope, to register in that scope with conditions on their practice. RAs are also not recognising the pressures on practitioners in rural areas, who may have attained additional expertise through the years, to work in discrete, advanced areas associated with their general scope. The inability of RAs to acknowledge these issues is limiting the numbers of practitioners able to provide services. 4, 13, 18, 29, 37, 113

Restrictive scopes of practice can be challenging in smaller health providers and hospitals. 37

Some restrictive scopes of practice are removing those with considerable skill from certain activities, while those who are less qualified are still able to participate. For example, experienced enrolled nurses are excluded from acute mental health, while psychiatric assistants are still qualified to participate. 37

The use of the powers under sections 21 and 22 should be the exception rather than the rule, as it encourages specialisation at a time when New Zealand needs more generalists. 22

Restrictions and conditions on APCs – such as the scope for general medical registration – are, in many cases, not being monitored or enforced. 33

Often older practitioners will move into advisory positions towards the end of their careers. They carry a great wealth of knowledge that needs to be acknowledged. Mechanisms should be in place to allow these practitioners to maintain their vocational registration. 22, 37, 87

The considerable overlap between the registered nurse and nurse practitioner scopes makes it difficult to articulate and evidence the difference between the two. There should be a return to one ‘registered nurse’ scope with authorisations on scopes of practice to evidence advanced competencies such as prescribing. 17

Employers are operationalising scopes of practice restrictively for their own protection and are not acknowledging the existence of, and need for, the therapeutic relationship between the practitioner and patient. 18

RAs do not seem to be following the requirements of section 13 of the Act, and are imposing unnecessarily costly requirements on practitioners and time-consuming, costly processes on themselves. 39, 73, 76

RAs and the Ministry of Health need to give practitioners and employers better guidance around what people can and cannot do, and what people can and cannot call themselves, and they need to monitor behaviour in this area actively. 57, 84

Scopes of practice seem to be achieving their intent. 74, 105

Service need should inform scopes and training programmes. This approach is not necessarily being taken; for example, in counselling psychology. 75, 77, 79, 85, 90

It is not clear whether scopes and the qualifications that underpin them can be approved by an RA for a time-limited period. 81

Scopes of practice are not intended to reflect ‘service needs’. 53, 81

Although it has not yet occurred, there is concern that RAs may be forced to bow to workforce pressures and vary their scopes of practice away from those that currently exist for medicine. 72

The Ministry should be able to explicitly instruct RAs to develop scopes of practice; for example, for counselling psychology. 84

The titles ‘registered nurse’, ‘nurse practitioner’ and ‘enrolled nurse’ should be retained to facilitate public understanding of their roles and how they are different from unregulated health care assistants. 104

Scopes of practice should be reviewed regularly. 104

Prescribing qualifications (sections 12 and 13)
Some RAs seem to have taken the introduction of the Act as an opportunity to unnecessarily increase the educational requirements for their professions. Whether this move has been made for the benefit of the public or for the benefit of the profession is unclear, but it is not driven by safety concerns and does not reflect service need. 4, 8, 10, 11, 31, 87

Often the requirements for overseas practitioners to register are not reflective of the practitioner’s clinical experience. Instead they focus on the practitioner’s theoretical knowledge as if they were fresh out of university, which they are not. 4, 8, 113

Some RAs recognise overseas practitioners for registration in teaching scopes, but do not recognise overseas practitioners who have been taught at those same universities for registration in a practise scope. 4

Often an RA will choose to impose undue cost by insisting on accrediting and monitoring all overseas courses itself, when the country in question has a quality assurance regime in place that is commensurate with New Zealand’s. In such situations, the RA could simply accredit those courses that have already been deemed safe by that country’s authority. 4

Often it is necessary to gain undergraduate qualifications followed by postgraduate qualifications to work in a discrete scope of practice. For example, undergraduate qualifications in diagnostic imaging are needed before a postgraduate diploma in mammography screening can be attained; such requirements may be costly and place unnecessary disincentives in the path of practitioners who might otherwise seek employment in the breast cancer screening workforce. The same effect may arise from the need to attain specialist qualifications, which are not currently offered in New Zealand or not necessary to undertake the broad work done by the profession; for example, the qualifications required to work in the field of adult care in dental therapy. There is also a disconnect in respect of qualifications in instances where practitioners may wish to move between scopes of practice but no bridging programmes are available to help them to do so. The RAs may not directly influence qualifications but they constitute a significant player in this area. RAs should make the Ministry of Health aware of issues such as these, and engage in a process to solve these workforce issues. 5, 9, 109

There needs to be a mechanism for resolving disputes between an accredited training organisation, employer or professional association and an RA. 22, 36

Yes, the qualifications reflect practice appropriately. 11, 21, 29, 36, 38, 43, 62, 64, 65, 74,75, 82, 90, 93, 95, 96

No, at times the qualifications do not reflect the scope of practice adequately, which can lead to role conflict/professional conflict, and public misunderstanding of the standard of care. For example, a midwife is expected to be capable of providing post-epidural care to a woman in labour; however, midwives cannot always fulfil this expectation, leading to confusion and poor hand-over for the patient. 1, 50

It is debatable as to whether nurses and midwives are fit for practice after their three-year degree. However, extending the timeframe to four years raises issues of cost, recruitment and infrastructure. 58

The Dietitians Board should be actively seeking more equivalent training institutions to accredit, as a means of encouraging more dietitians into the workforce. Sections 12 and 13 seem to be misunderstood in this regard. 71, 79

If the intent of section 12(2)(a) is to allow RAs to use experience as a qualification, even if the prescribed qualifications are silent on whether experience is required, then this intent is not clear. 81

Section 15(1) suggests that a practitioner may be registered only if they are competent to practise in the full scope, yet section 15(3) allows RAs to vary qualifications. However, under the Act, RAs must gazette prescribed qualifications and consult on them. If the intent is that varying qualifications should be permitted in specific cases to allow for limited registration, then this intent needs to be made clear. 81

The New Zealand College of Clinical Psychologists disagrees with the New Zealand Psychologists Board's provision of alternate routes to qualification for the clinical scope that are not related to university courses. 97

There is debate as to whether the nursing degree should be extended to four years. This is supported by some in nursing. 82

The Psychologists Board should allow an 'overseas equivalent' to the university-based postgraduate diploma in clinical psychology rather than just an 'equivalent'. Training for entry into the clinical scope should be university-based. 98

The undergraduate degree for registered nurses should be reviewed. 104

Generally qualifications in occupational therapy are appropriate for those practitioners trained in the New Zealand environment. However, qualification requirements may not necessarily fit well with those practitioners who are coming or visiting from overseas. 107

Part 3 of the Act: Competence, fitness to practise and quality assurance

Registration and recertification

Information is not available to assess the RAs' processes and/or performance in assessing practitioners where competence/recertification has not been achieved. Reporting requirements, audit processes and public disclosure should be strengthened. 1, 18, 29, 43, 56, 90

In some cases, RAs are placing the bar too high and are operationalising the Act defensively. This approach requires practitioners to practise in an unnecessarily defensive and resource-intensive manner. The RAs that are taking this approach are doing so more to enhance the standing of the profession and to protect the reputation of the RA, than to ensure the safety of the public or reflect service need. Often the requirements for recertification (such as attendance at courses) seem to be put in place merely to allow the RA to demonstrate that it is meeting the requirements of the Act rather than to meaningfully ensure the ongoing competence of practitioners. The increase in costs associated with taking practitioners out of the workplace is often passed on to the practitioner and patient. In some instances, the cost may force practitioners to leave, or not re-enter, the profession if they perceive the costs outweigh the benefits of continuing or returning to practise. The cost and the lack of flexibility and meaningful assessment are having significant impact in rural areas. 4, 5, 8, 10, 18, 19, 29, 31, 37, 39, 44, 46, 56, 64, 65, 76, 77, 79, 80, 85, 87, 94, 95, 102, 103, 104, 107, 113

Competence and recertification programmes do differ and both are beneficial. However, there seems to be confusion as to what each is supposed to be used for. Competence programmes should be used where a practitioner's competence is in question around specific aspects of clinical best practice. Recertification programmes should be used for ensuring the practitioner is competent to practise before an APC is issued. RAs should jointly develop principles to underpin these programmes. 1, 4, 7, 15, 19, 21, 22, 24, 32, 37, 43, 44, 46, 47, 51, 52, 53, 55, 57, 64, 70, 71, 73, 79, 80, 82, 85, 95, 96, 98, 102, 104, 105, 106, 108

There may be a perceived gain in competence and public assurance if all authorities were required to institute recertification programmes. However, such programmes should operationalised in a manner that is appropriate for the profession, cost-effective and, where possible, consistent with other professions. 4, 5, 18, 19, 21, 22, 28, 29, 32, 37, 38, 40, 43, 44, 51, 53, 55, 58, 62, 65, 76, 79, 81, 85, 89, 94, 95, 96, 106, 113, 114

Recertification and competence programmes are very similar and should be combined. 65, 82, 90, 114

The English language test required by the Medical Council is unnecessarily restrictive. 49

Part-time practitioners should meet the same recertification requirements as full-time practitioners. There is no such thing as a partially competent practitioner. 5

Many RAs only become aware through informal networks that certain practitioners do not hold a current APC. Reporting requirements should be improved. It should be mandatory for employers to inform RAs if they are employing practitioners without a current APC. 5

For those professions that are not registered, but that believe the activities of their practitioners may pose a risk to the public, discipline is difficult. It is difficult to discipline those who are found to be incompetent, as the relevant association with whom the practitioner may be associated has no legal standing. 14, 42, 66

Recertification has been a clear benefit to come from the Act for midwives and has been embraced by the midwifery profession. The cost is an issue, but the Midwifery Council of New Zealand is dealing with it. 15, 53

The Nursing Council of New Zealand has generally done well in operationalising the Act. Linking Professional Development and Recognition Programmes with recertification is a good initiative. However, there seems to be confusion in the profession as to what is evidence of practice competence and how a practitioner is to provide this evidence. 17, 40, 65, 80, 82

RAs should make greater use of peer review to ensure competent practice. 17, 40, 65, 80, 82, 95

The Nursing Council should appoint an approved independent assessor prior to referring nurses to educational institutions for competence issues. 82

The costs of recertification are significant for practitioners and service providers, and these costs should be reflected in the RAs' approach to this aspect of the Act; for example, RAs should recognise existing employer-based continuing professional development (CPD) programmes. Additionally, thought needs to be given to the way central government funds DHBs and service providers, and the way DHBs fund service providers that they contract with. 26, 28, 31, 37, 65, 73, 98

Time to prepare and complete recertification should be part of all registered health practitioners' contracts with DHBs. 47

It is difficult to know whether the competency standards required by employers are consistent with the standards required by the RAs; each DHB has a different way of approaching this issue. It can create a 'double requirement', as in the case of occupational therapists. 37

RAs should notify employers when practitioners are under investigation for competence issues or when restrictions are placed on APCs. 38

There is scope for public confusion between what it means to be registered and what it means to hold an APC. Only APC holders should be able to use a restricted title. 40

Although recertification is essential and areas must be prescribed, the requirements for such recertification must be flexible, to allow for innovation by the RA. 43

Some employers are not aware of the implications of the Act and thus do not follow up the need to hold an APC; for example, for enrolled nurses to practise as school nurses. Education to increase awareness in this regard is necessary. 44

RAs' processes are costly and time-consuming, and are not always accurate. 46, 54, 58

Research on the effectiveness of current recertification regimes should be undertaken. 51, 74, 96, 105

Recertification is having a positive effect on the skills of practitioners, although long-term analysis cannot be performed at this point. It is felt, however, that less attention is paid to some areas (such as cultural competence) than to other areas. 52, 104

Online recertification programmes may be a cost-effective way for RAs regulating small professions to institute recertification programmes. 52, 53

Online recertification does have its drawbacks (not explained). 70

Funding needs to be provided for peer review to ensure greater use of this valuable competence assessment/maintenance tool. 57, 58

Practitioners should be required to notify the RA of a change of address within 15 working days. 60

Consider tighter penalties for practitioners and employers who do not renew APCs on time. 60

Section 35(2) notifications could have a profoundly negative impact on practitioners if the allegations reported on turn out to be false. 62

Some RAs are imposing standards for registration and recertification on overseas practitioners that are different from those imposed on domestically trained practitioners. 69

The Medical Council is assessing overseas doctors appropriately. 74

CPD programmes, including peer review, are valuable and essential in professional self-development and monitoring. However, they are not sufficient by themselves to ensure safe standards of practice. This principle applies in most professions. 74

RAs should make greater use of professional organisations, employers and other bodies in recertification processes, in monitoring of the competence of the profession and in identifying incompetent practitioners. 76, 77, 95

Some practitioners are not registering or are not registering promptly. The Act is not clear on whose responsibility these practitioners are and does not provide for a penalty. At the moment, the only penalties are either conviction under section 7 or disciplinary

action on the part of the RA. Both penalties are time-consuming and unduly expensive and are also overly punitive considering the magnitude of the offence. Responsibilities should be clarified and appropriate penalties, such as a fine, should be able to be imposed. 106

Some practitioners do not understand the requirements for recertification; better information from RAs needs to be forthcoming. 107

Competence (section 40)

Compulsory reporting of competence concerns by peers is not a good idea. Many of the professions in New Zealand are small and thus anonymity on the part of the complainant is difficult to maintain. 4, 5, 10, 15, 18, 23, 29, 31, 37, 40, 43, 44, 51, 55, 72, 79, 85, 92, 103, 104

Compulsory reporting of competence concerns by peers is a good idea, but needs to be undertaken in a way that avoids fostering an unhelpful employment climate. It should be a requirement that peers report their concerns to the employer or a professional peer in the first instance, and the report then goes from the employer to the RA. 17, 24, 38, 65, 70, 74, 81, 106

Compulsory reporting by employers is, on the whole, working well. However, some employers view this mechanism as a substitute for performance management systems. This issue is being managed by the Medical Council through memorandums of understanding. 19, 24, 38, 46, 80, 104, 114

The Act requires action on the basis of suspicion, and competence reviews are expensive. The RA should be required to undertake an investigation before undertaking a review and notifying parties listed in section 35. 1, 29

RAs should be able to initiate competence reviews at any time there is a concern over a practitioner's competence. 1

RAs and the Ministry of Health should develop guidelines to ensure consistency in: the notification of risk of harm; activation of competence reviews and level; constitution of competence programme imposed; what information is reported on publicly; and how that information is made public. These guidelines are necessary to ensure employers and practitioners understand their responsibilities and obligations. 4, 24, 50, 63, 64, 87, 82, 96, 107

Section 36(4), which allows the registration to conduct a competence review on any current APC holder, should be repealed as it is a totally unacceptable imposition on practitioners and is open to abuse by the registration authority, which could victimise practitioners or groups of practitioners. The potential for the abuse of this provision far outweighs any good that imposing competence reviews on practitioners with good track records could possibly achieve. Health practitioners should have some rights too. 4

RAs should be required to make available information on numbers of practitioners who have been subject to competence inquiries and on the outcomes of those inquiries. The

Ministry should then collate this information across RAs and make it publicly available. 5, 7, 12, 46, 58, 90, 107

Section 35 notifications happen too slowly. They need to be sped up in some way to protect the public from a practitioner who may still pose a risk. 24, 29, 38, 40, 46

Sections 34 and 35 only cover employees and not practitioners with admitting rights or access agreements. Accordingly private hospitals are not required to notify RAs if they have withdrawn visiting privileges of a health practitioner for reasons related to competence. 7

Once an RA has reason to believe a risk of harm exists, it should be required to notify more parties than just the employer, to cover situations where the practitioner may not be directly employed by an organisation. 7

RAs should also be able to review competence when a practitioner has brought the profession into disrepute. 38

Often review recommendations are not followed or enforced. 10

Interim suspensions should be reserved for only the most serious of cases; other avenues should be explored first. 11, 22, 29, 37, 102, 107

The appointment of dedicated professional competency advisors by some RAs has worked well. 11

Many practitioners are afraid of becoming 'whistle-blowers' by reporting the incompetent or unfit practice of their colleagues. They do not feel confident that they have all the necessary information around the processes that will be started once a complaint has been made, and their obligations and rights in those processes. RAs should develop uniform processes and advertise information on the Act, its requirements, and the RAs' processes to the professions. 12

RAs should be able to initiate competence reviews where: a current APC is not held; a practitioner has not practised in more than three years; there is inadequate evidence of maintenance of competence; or there has been a series of complaints, each of which may not be serious in nature on its own but cumulatively cause concern. The RAs should decide when the review is appropriate. 24, 53, 106

Reporting by employers should be voluntary, not mandatory. 29

In some instances it is more expedient, and results in a better outcome, if competence to practise concerns are dealt with in the workplace. 29, 53, 95

The process of identifying areas of an individual's practice that need improvement and the system to allow this to happen have not yet been developed, either in public or in private practice. Greater use of credentialing and guidance on when and how reporting should be undertaken is needed. 33, 79, 95

The Act should allow for sharing of competence information among provider organisations (such as DHBs and private hospitals). 41

Where a practitioner is referred to an RA for competence issues, it would be useful for the RA to inform the referrer as to whether a review was carried out and what the outcome was. 41

RAs should be able to initiate competence reviews where there is a demonstrated lack of ability to communicate, lack of cultural competence, or failure to meet recertification requirements. These issues may not reach the test for 'risk of harm', but competence reviews would be a useful tool in addressing them. 43

The flexibility of competence programmes have allowed practitioners, found to be lacking, to come up to standard while still ensuring services are available to communities, particularly in isolated areas. 51

There needs to be clarification as to what the agencies notified under section 34 will do with the information. 51, 53, 73, 81

Risk to the public may be non-existent if a practitioner has been dismissed from employment for lack of competence, although the RA involved may wish to conduct a review. 52

RAs should also have to notify of harm if a practitioner has not engaged in a recertification programme or met/complied with conditions. 53

Consideration should be given to having a 'workforce development risk fund' to allow individuals and small business employers to access and cover the costs of assisting professionals back to full competence. 58

Primary Health Organisations (PHOs) should be informed of competence concerns. 58

RAs only become aware of competence issues when complaints are made. A system of ongoing reviews that links to CPD needs to be established. 74, 75

The requirement to notify a set of agencies may act as a deterrent to notifications of incompetence. 74

The Act is focused on the individual practitioner and, consequently, systemic failures are ignored in reviews of competence, discipline and notification procedures. 75

Employers need to be more supportive and vigilant in respect of their employees' competence or lack thereof. 75

All complaints regarding registered health practitioners received by the Health and Disability Commissioner should be referred to the RAs. This will enable RAs to discern possible patterns that may indicate competence issues. 81

Referral procedures under the Health and Disability Commissioner Act 1994 should be tightened to allow RAs to act expeditiously and effectively. 81

Thought should be given to RAs developing team-based competence programmes. 81

Organisations should be named when staff have been found to be negligent. 82

It is not clear if all RAs are notifying employers when notifications of competence are received; instead, some RAs may be choosing to use the rehabilitation mechanisms of the Act in the first instance. A consistent approach that acknowledges the needs of the employer to ensure patients in their care are attended by competent practitioners is necessary. 92

The scope of section 34 should be broadened to include instances where practitioners may not pose a risk to the public, but may pose a risk to other practitioners or the work environment; for example, where a practitioner is abusive towards other staff. 92

Foreign doctors are over-represented in complaints to the Medical Council. The Council's requirements do not seem to address the needs of foreign doctors. 94

Some employers are reluctant to employ or support a practitioner with conditions on their practise. This reluctance reflects a lack of understanding of, and confidence in, the Act on the part of employers and not necessarily inadequacy in the Act's provisions around competence. 104

The options available to an RA to suspend an APC, impose conditions or do nothing are not always appropriate. Often imposing conditions carries with it a stigma that is disproportionate to the offence. RAs should be able to accept an undertaking from the practitioner that they will fulfil conditions within a specified period of time, without having to formally place conditions on the practitioner's APC. 104

RAs should be required to inform a practitioner's employer or business partner of a potential risk of harm. The other notifications should not be mandatory; instead the need for one should be assessed on a case-by-case basis. 106

Inability to perform required functions because of mental or physical condition

Compulsory reporting of fitness concerns by the employer is not working, particularly where the employer is not a member of the profession and thus does not know what constitutes safe practice or may be driving the unsafe practice based on profit considerations. Greater clarification or more guidelines are needed as to when reporting should take place. The reporting process also needs to be linked to issues relating to the Privacy Act 1993. At present, reporting may happen before it is necessary – that is, some employers are overly cautious. There should be public reporting of notifications by employers. 1, 5, 32, 52

The RAs should maintain a 'register of fitness to practise' to allow the public to identify practitioners with a history of incompetence or misconduct, etc. 17, 47

Some authorities have struggled in operationalising section 49. There is a clear lack of consistency among authorities as to how functions under this section are carried out. 11

Clarification needs to be given to the responsibilities of an employer or practitioner where a practitioner presents as a patient and that presentation leads to concerns over the practitioner's fitness to practise. 41

Guidelines should be given as to what is meant by 'unable to perform required function'. Guidance should address when an issue of fitness concerns can be dealt with by an employer and when it should be referred to an RA. 41

The Accident Compensation Corporation should have to inform RAs of a practitioner's inability to practise. 43

RAs should have access to information from other organisations (the Ministry of Health, Immigration, etc) that maybe relevant to a practitioner's ability to practise. 43

Clarification is needed as to what happens to a health practitioner if they do not report. 82

Quality assurance activities

PQAAs are necessary and should be retained. The process is stringent but such stringency is also necessary. 5, 7, 11, 17, 18, 19, 31, 33, 37, 46, 50, 55, 64, 70, 71, 72, 73, 95, 104

With the climate of 'openness' the Act fosters, there is doubt regarding the need for PQAAs. Their use appears to have diminished since the arrival of the Act and a lot of confusion and dissent about their use remain. There are competing needs between public reporting and the need to foster quality improvement. This section should be the subject of a wider review. 74

PQAAs are underutilised for their educational benefit. Outcomes should be reported as case studies to like professions for educational purposes. 5

Organisations that operate PQAAs should be required to report on how often they are used and how they contribute to improved quality and safety. 5, 7

The section of the Act dealing with PQAAs needs to be reconsidered. Although PQAAs are an important safety tool, there are issues surrounding their operation, including: the technical aspects of obtaining PQAAs; the reporting requirements; paucity of enforcement; and legal concerns around serious incidents. The adoption of PQAAs has not been consistent across all practitioner groups, as the Act introduced them to all practitioners except doctors, for whom PQAAs had been established already under earlier legislation. The role of PQAAs as a protective measure across practitioners' activities is of benefit, but that role is yet to be fully realised. 5, 7, 31, 50, 72, 73, 92, 95

The relationship between PQAAs and reporting of sentinel events needs to be addressed. 5, 37, 46, 72

Wide use of PQAAs is contrary to moves towards open disclosure. Some patients are being excluded from discussions around adverse events that have happened to them based on the activity being covered by a PQAA. 7

PQAAs are used by many DHBs in respect of perinatal mortality review processes. However, Lead Maternity Carers and general practitioners who work in a private capacity, but may have access agreements with DHBs, are not covered by these PQAAs. This situation is unacceptable. 15

Research should be undertaken on the number of PQAAs established. If the uptake is shown to be low, then the provision should be reconsidered to make the process less bureaucratic. 23

In terms of reporting, it must be clarified how compliance can be measured, what value reporting has, and that the resources necessary to produce and monitor these reports are justified. 33

The Minister of Health should not be able to override PQAAs. 46

The ability of the Minister to authorise disclosure of information under section 61 should be wielded elsewhere due to the potential for the Minister to bow to political pressure. 72

Social workers should be covered by PQAAs. 72

There should be no requirement to report on PQAAs, just a requirement to specify them. 79, 85

It might be time to review PQAA provisions to see whether the benefits previously enjoyed by medical practitioners have been fully communicated to, or realised for, other health practitioners. It might be appropriate for RAs to be able to approve PQAAs as part of a competence improvement/assurance strategy. 81, 104

Sections 55 to 58 should be reviewed to either remove the ‘responsible person’ or remove the requirement that they be independent. The responsible person should at least be a member of the team within which the PQAA is taking place. 95

The reporting requirement in section 58(1) should be removed and programmes should be required to maintain their own documentation. 95

Part 4 of the Act: Complaints and discipline

Professional conduct committees

PCCs require professionals to spend time away from their practice. This requirement can be a concern for a small profession. 1

Practitioners have noted appearances before PCCs and criticism by PCCs for not following a ‘checklist’, when to do so would have been a waste of patient and practitioner time and resources, as it was obvious the tests were not needed. 4

The processes operated are too slow, costly and not open and transparent. PCCs often get bogged down in legalistic process and, in the meantime, the practitioner can keep practising. The threshold should be lowered to ‘risk of harm’ and interim suspensions should be available without the practitioner having made a submission. 4, 5, 7, 10, 18, 27, 43, 58, 75, 77, 104

Best practice guidelines should be developed around operationalising PCCs. There is a lack of consistency among RAs as to how PCCs are conducted. 7, 74

Where a practitioner is referred to the HPDT, the Tribunal should have the power to request information from the RA in respect of any competence review that may have been undertaken and the outcome of that review. 25

Under section 39(3) there may be scope for providing for adequate time to enable the employee to respond and make a submission. There may also be value in requiring the RA to liaise with the employer to discover the effects of a suspension. 37

RAs need to provide more information to the profession on how this process works. 46

PCCs are often used for minor matters, such as failure to renew an APC on time; this kind of use is not appropriate. 104

Health Practitioners Disciplinary Tribunal

A single Tribunal is appropriate. 4, 7, 10, 11, 25, 51, 53, 55, 62, 80, 81, 82, 87, 89, 95, 98, 102, 104, 105, 114

The HPDT does not need the capacity to deal with multidisciplinary teams; practitioners must be judged by the standards of their own profession. 1, 46 (nursing), 62, 70, 73, 80, 82, 95, 96, 102, 104, 106

The HPDT does need the capacity to deal with multidisciplinary teams; however, panel constitution will be very important, as will the HPDT’s ability to deal with the systemic failures that underpin these cases, and the RAs’ ability to co-ordinate. 4, 5, 7, 10, 11, 19, 22, 24, 29, 33, 40, 46 (medicine), 51, 53, 55, 71, 75, 79, 81, 85, 87, 94

The HPDT could deal with multidisciplinary or team hearings if necessary by careful selection of panel membership and/or appointment of technical advisors under Schedule 1, clause 16. 25

It has been suggested that the threshold for referring a practitioner to the HPDT from a PCC be lowered. This is not a good idea. 13

The discipline function should be given to RAs to encourage consistency in standard setting, to increase efficiency, to drive policy and because of the increased cost associated with HPDT hearings. 106

Membership of the HPDT

The mix of practitioners on the HPDT is appropriate, but the appointments process needs to be more robust. There needs to be better checking of references to ensure no practitioners are appointed who are not of good standing within the profession. 25

There should be more laypeople on the Tribunal. 51

It is not clear what value laypeople add. 70

The constitution of the panel should ensure a complaint is heard by practitioners who are not just professional peers but also practise in the same area. 106

The appointments process should be more open and transparent. 107

Cost of running the HPDT

The operation of the HPDT should be funded by the Ministry of Health. 1, 5, 24, 32, 51, 52, 106, 108

The operation of the HPDT should be jointly funded by the Ministry and the RAs. 10

The operation of the HPDT should be funded by professions through their RAs. 21, 43, 55, 82, 90, 95

The training of HPDT members is necessary. Financing must also be resolved. 24, 25, 96, 105, 107

The cost of holding hearings and running the HPDT is a concern. The HPDT should have a single secretariat, to minimise wasted administration and duplicated costs. The secretariat should be adequately resourced. 7, 11, 15, 24, 25, 29, 43, 95, 102, 104, 106

It is dysfunctional for the Chair of the HPDT to have to deal with multiple executive officers. There is also the potential for conflict of interest where the officer has another role within the RA. 25

A cap should be placed on the disciplinary levy an RA is able to charge. 104

Part 5 of the Act: Appeals

It is concerning that, when a charge is upheld by the HPDT, the practitioner can appeal to the High Court for name suppression. In a civil or criminal case when a charge is upheld, the individual's name is made public. It should be the same if a charge is upheld by the HPDT. 5

The appeals process works well, but is costly. RAs can only recover a small portion of these costs where an appeal is found in their favour. 24

Part 6 of the Act: Structures and administration

Registration authorities and registration authority structures

Authorities should not be forced to regulate new professions. If there are concerns around setting common standards in areas of practice that overlap between professions, then joint standards groups should be established to address these concerns where needed. There is no evidence to suggest that a combined secretariat will reduce costs; a dedicated secretariat, on the other hand, provides the authority with the autonomy to develop processes that suit its individual needs. 1, 15, 18, 24, 75, 114

Evidence is lacking as to whether it is better to have one or several authorities regulating professions under the Act. Nonetheless, it is clear that a proliferation of authorities (particularly small authorities) will increase costs and decrease efficiencies and co-ordination on common issues. Section 3(2)(a) states that the Act seeks to provide 'for a consistent accountability regime for all health professions'. Given the very different ways in which the various RAs have approached their responsibilities under the Act, this consistency has not been achieved, for example, in respect of recertification and competence review processes, registration systems and processes, information release standards and processes, and engagement with employers. The number of authorities that already exist in a small country like New Zealand, with the potential for more of them, increases compliance costs even further.. As a result, the cost of compliance for the professions under the Act can vary dramatically, as can the cost of running an RA under the Act. A way needs to be found to regulate new professions and address cost and consistency issues associated with running RAs, while maintaining professional identity (for example, for anaesthetic technicians). 1, 2, 4, 5, 7, 10, 28, 29, 31, 32, 33, 37, 38, 40, 41, 43, 45, 50, 62, 66, 79, 81, 82, 85, 86, 87, 89, 91, 95, 97, 104, 108

Separate dental therapy and dental hygiene courses are no longer available and the first graduates with a conjoint dental therapy/dental hygiene qualification will graduate at the end of 2008. Therefore, it is timely to amalgamate the dental therapy and dental hygiene boards of the Dental Council of New Zealand. 9
The process for assessing unregulated professions for regulation and establishing authorities is time-consuming, but should not be changed until more information can be collected on where deficiencies may lie. 14

Criteria should be developed to assess applications for regulation under the Act. The threshold for regulation should be raised. Assessment should be based on: evidence of harm and frequency of harm; impact on public safety from regulation; and a cost–benefit analysis and prioritisation of proposals for regulation against perceived risk of harm. Critical mass should be considered when establishing stand-alone authorities. 22, 28, 29, 32, 33, 41, 43, 50, 65, 70, 105

The current authorities in the Health Regulatory Authorities of New Zealand are working well together. The practice of professional self-regulation is very important and should not be endangered by the possible amalgamation of boards. 24

The number of RAs should be reviewed, and reduced where it is possible to combine like professions under one RA. 28, 106

Stronger requirements should be placed on RAs to collaborate with DHBs and the wider health sector. 28

A scope of practice should be developed for pharmacy technicians by the Pharmacy Council of New Zealand. 42

RAs' processes are costly and time-consuming. This cost has increased significantly since the Act came into force. 46

Clinical physiologists, counsellors, nutritionalists, speech and language therapists, ambulance officers/paramedics, social workers, massage therapists and nutritionalists need to be included under the Act. 48, 68, 78, 82, 85, 87, 101

RAs should be made more transparent. Mechanisms need to be put in place to ensure RAs work in the public's best interests and do not confuse their role by advocating on behalf of the profession they regulate. 50

There is merit in professions sharing administration support, but not in amalgamating RAs. Any professions currently under consideration should be established as individual boards, and be encouraged to share current administration structures of the Medical Council or Medical Sciences Secretariat (if appropriate); for example, this measure might apply to anaesthetic technicians. This measure should be an interim solution until the end of the review. 50, 52

Funding of any structural changes to the RAs should come from central government. 52

Consideration should be given to establishing to trans-Tasman RAs. 62, 82, 102

The Medical Council should not regulate anaesthetic technicians. 72

Herbal medicine has been approved for regulation and should be regulated under a stand-alone authority known as the Natural Health Registration Authority. This regulating body would provide an authority to regulate other natural health professions such as naturopathy and homeopathy should they become regulated. 83

Either the Medical Council or the New Zealand Medical Radiation Technologists Board should take on anaesthetic technicians. 104

If RAs are amalgamated there is concern that smaller professions will find it harder to be heard. 107

Membership of authorities

The system of appointed members is working well and should be maintained. Although elected memberships are appealing, there are significant concerns that elected members may feel a duty to represent the views of those who elected them. It is also not guaranteed that an election will produce an RA membership with the skills necessary to undertake the RA's functions or with the broad perspective necessary to protect the public. There should be a mechanism to appoint members in an open and transparent manner. The process needs to ensure that members have the necessary skills to undertake the RA's functions. The process should also have a mechanism to ascertain the profession's views on potential appointees. Training of members should be required as well. 1, 2, 7, 15, 21, 24, 51, 70, 81, 82, 85, 91, 92, 96, 102, 106, 114

Elected members should be allowed or, alternatively, another way should be found to make memberships more representative of the profession. Strict, consistent criteria for electing members should be followed in order to ensure openness and transparency. An open, transparent system for electing members would give the professions a sense of empowerment and would ensure the views of professions are duly reflected in decisions made by RAs, particularly in respect of developing scopes of practice and setting qualifications. Association or society executive members should also be eligible for both appointment and election. The current all-appointed system does not ensure RAs have the necessary skill sets. As a result, some RAs have reasonably significant areas of skill shortages (for example, educational knowledge) and the input from their individual members varies hugely. The current system also does not prevent RAs from being captured by members appointed from minority groups that do not reflect the broader views of the profession. 4, 5, 10, 11, 22, 23, 29, 33, 37, 38, 39, 43, 50, 62, 64, 72, 74, 79, 89, 90, 95, 95, 100, 104, 107

Performance assessment processes should also be put in place. 11, 29, 32

Many RAs meet too infrequently. Members should recognise their duties as members of RAs and make themselves available to meet frequently enough to deal with issues in a timely manner. 4

The total period for which a person can be appointed should be reduced to provide a fresh perspective on an ongoing basis. 10, 29

Membership of RAs should include legal expertise. 4

RA memberships should be reflective of the scopes of practice and numbers of practitioners registered in those scopes. 4

The current definition of 'layperson' does not require a consumer perspective. This definition should be amended. 5

The current definition of 'layperson' should be amended to that developed by the National Ethics Committee in 2002. 23, 104

A practitioner should not qualify as a layperson simply by having their name removed from the register. A nurse will always be a nurse. 106

RAs have too many laypeople on them who do not understand the professions the RA regulates. 32

Appointments processes should be developed that appoint in an open and transparent manner, based on the skills necessary to undertake the RA's functions. 23, 29

All RA members should be elected. Skill sets for RA membership should be developed to guide voters, and training for members should be provided. There should be no political interference in the membership of the RA. 18, 19

Including lay members is important. However, increasing the number of lay members would increase costs for RAs, as greater use of secondment provisions to subcommittees would be required for technical work. 51, 52, 53, 58

There should be elected members, but the majority of RA members should be appointed lay members. 58 (medicine)

It may be difficult for authorities to fulfil regulatory functions where factional disagreements occur within an authority or professional group. 59, 71

Under previous legislation, the Ministry of Health and educational representatives on RAs fulfilled the important role of ensuring the RA stayed within the intent of the Act and was well informed about education requirements and course availability. Ministry officials and education representatives should be appointed to RAs to provide guidance. 69, 82

There has been concern expressed over the influence of the training school in the business of the Dietitians Board and the Physiotherapy Board. 85

RA members seem to vary widely in their ability. This variation is a reflection on a poor appointments process. 69

The Ministry could provide governance courses for appointed members. 96

Section 120 should be amended to reflect the intent of Māori representation. 104

Section 120 should be amended to require that a majority of members of the RA be health practitioners 'regulated by that authority'. 104

Lay representation has been very beneficial for the Optometrists and Dispensing Opticians Board. Continued lay representation is imperative. 108

Functions of authorities

The lack of consistency, consultation and transparency in the way that RAs have developed and implemented their policies/responsibilities is a concern. The Act was intended to provide a degree of consistency across all registered health professions. Gaining consistency is particularly difficult for RAs regulating smaller professions, due to

a lack of resources for these RAs. 2, 3, 4, 8, 9, 10, 11, 17, 23, 29, 37, 38, 50, 59, 79, 108

The RAs are doing well and improving. 40, 62, 64, 65, 70, 71, 82, 102, 105, 114

Informing the public of the regulation of services provided by the RA should be a function. This activity would assist the public to better understand the purpose of regulating the profession. 1

Authorities should be required in legislation to post annual reports on their websites. 4

RAs do not always inform practitioners of their rights, particularly in respect of their right of appeal. 4

Some RAs are being unduly influenced by their Australian counterparts. 4

In some instances there have been issues with authorities' ability to maintain an accurate register. 4

RAs should clearly define what is expected of practitioners in terms of cultural – and specifically multicultural – competence. Cultural competence should constitute a part of clinical competence rather than recertification, and should be enforced in respect of registering overseas practitioners. 21, 77

The professions should be responsible for developing ethical standards, not the RAs. Placing this responsibility outside the professions leaves open the potential for political interference and/or conflict of duty, as happened, for example, when the leaders of Nazi Germany ordered medical experiments to be conducted on Jewish people. 23, 50, 104

Functions relating to professional conduct should be included. 24

Efficiency has been improved under the Act, in part due to autonomous, dedicated secretariats. 24

Consultation requirements in the Act need to be strengthened. Often practitioners and the public are unaware when new scopes are being developed or when existing scopes are changed. Additionally, allied health and NGOs tend to get left out of conversations, with the result that scopes are developed for the DHB environment, in which others have to try to fit. Finally, RAs' links with educational institutions are not as strong as they could be. 2, 3, 4, 8, 9, 10, 11, 17, 23, 29, 33, 36, 37, 65, 69, 82, 85, 95, 95

There are faster and more relevant ways to inform the public and profession of changes to scopes and fees other than by gazetting – ie, through RAs' websites. 43

RAs should gather data on their respective workforces and make this available. 53

There is concern that RAs may go, or may have already gone, beyond what their statutory role permits – for example, by advocating on behalf of the profession it is

obliged to regulate. If an RA steps out of its statutory boundaries, then the Act has no provision to prevent it from doing so. 23

An RA's duty is protection of the public, not advocacy for its profession. Some RAs have shifted into areas that are more properly the domain of a union or professional body. 50

A function should be included that allows an RA to do anything that is 'generally within the scope of its authority, to do whatever may in its opinion be necessary for the effective administration of the Act'. 106

Technical issues relating to authorities and the HPDT

RAs should be subject to the Official Information Act 1982 to give the public and professions access to information through more open and transparent processes. 1, 2, 4, 29, 36, 69, 79

As well as being subject to the High Court, RAs' processes should be subject to the Ombudsmen Act 1975 or to a specific Ombudsman for RAs, which would need to be established. 2, 4, 7, 11, 18, 36, 95

RAs should not be considered public entities. The increased costs will not increase the level of protection for the public. 24, 43, 51, 53, 81, 96, 106, 108

RAs should be subject to the Public Finance Act 1989 and Crown Entities Act 2004 to ensure more openness and transparency. 50

The Act should be amended to allow the RA or HPDT to make an order to uplift copies of medical records (or be satisfied that the practitioner concerned has made suitable arrangements for continuity of care) whenever it suspends a practitioner's practising certificate, or whenever a practitioner is struck off the register. 30, 41

A provision should be included allowing health workers who present no risk to the public to work under the supervision of a registered health practitioner who has a code of practice defining the activities and supervision requirements of these workers. 39
A provision should be made, following on from the Medical Practitioners Act 1995, that allows registration to be declined on the basis of the applicant not being a 'fit and proper person'. 43

The practice of telemedicine is difficult in New Zealand as, under a strict interpretation of the Act, those from another country would be required to be registered in New Zealand, which is problematic. 43

Amend section 3 to include definitions of 'employer', 'publication', 'risk of serious or permanent harm', 'emergency' and 'training'. Also clarify the words 'oversight' and 'supervision'. 43, 73, 79, 81, 85, 107

Section 7 should clarify that it is the Ministry of Health that undertakes enforcement around section 7 breaches. 52

Section 8(2) relates only to practitioners performing a service within their scope that they are not permitted to perform. It is not transparent for the public as there is a lack of awareness of scopes, and generally the public assumes practitioners carrying out procedures are qualified to do so. 81

Section 8(3)(b) should be amended to clarify that 'training' must be approved by the RA. 81

Section 9(5)(b) should be amended to reflect only training approved by an RA. 81

Section 12(2)(a) needs to be amended to allow RAs to treat experience as a qualification, even if the prescribed qualifications are silent on whether experience is included as part of that qualification. 81

Section 15(1) suggests that a practitioner may only be registered if they are competent to practise in the full scope, yet section 15(3) allows RAs to vary qualifications. However, under the Act RAs must gazette prescribed qualifications and consult on them. If the intent is to allow variation, and qualifications are intended in the instance of specific cases to allow for limited registration, then these intentions need to be made clear. 81

Section 16 has too high a threshold for declining registration. Other costs owing, such as appeals costs awarded and competence programme fees owing, should be a basis for refusing registration. This condition should also apply to sections 26 and 27. 24

Section 16 should allow the RA to consider attitudinal matters relating to a practitioner's approach to fitness to practise determinations of the RA. 24

Section 16 should allow the RA to consider whether or not the applicant is fit and proper and of good standing to be registered. 106

Section 16(d) should be amended to read 'physical and/or mental disorder' instead of 'some mental or physical condition'. 74

Section 16(h) needs clarification as to an RA's ability to establish current competence to practise prior to restoring a practitioner's entry to the register. 96

Section 22 sets out conditions that may be placed on a practitioner's scope of practice, but does so in a manner that suggests the conditions exist to restrict practice rather than to allow for the inclusion of additional services. The section needs to be amended to make it clear that conditions may be placed to allow for expansion of a scope. 51, 81

Section 27 should make it more explicit that RAs may decline to issue an APC to practitioners who have failed to establish that maintenance of competence. 81

Section 28 should not be subject to 'right to be heard' submissions, given the minor and standard operational nature of the provision. 24

Section 29(2) should allow RAs to issue APCs to applicants in a different scope of practice to the one they applied for. 43

Section 30 provides that a practitioner who is applying for renewal of an APC should be deemed to hold an APC from the date of the application. Time should be allowed for competence checks to be done. 24, 81

Section 31 is ambiguous as to how long an interim practising certificate (IPC) can be issued for. Section 31(2) should be amended to allow the issue of IPCs for such a period as the RA considers reasonable. 53

Sections 33(2)(c), 4(1)(b) and (c), and 4(2)(b) and (c) need to be reworded to give them teeth and support enforcement of related sections, for example, sections 7 and 8. 24

Section 34 should be amended to adopt the lower threshold in section 36(4)(a). 7

The scope of Section 34 should be broadened to include instances where practitioners may not pose a risk to the public, but may pose a risk to other practitioners or the work environment; for example, where a practitioner is abusive towards other staff. 92

Section 35 should be amended to allow RAs to notify 'potentially affected parties' (including associations, employers, individual practitioners, private hospitals, etc) while allowing more discretion as to when the notification should occur. It should also be amended to require the RA to be notified if a practitioner has been suspended or dismissed for misconduct, or if the practitioner has left employment before the conclusion of an employer-instigated process to address competence concerns. 1, 7, 36, 38, 43, 95

Section 35 should be amended to set the condition of 'a **serious** risk of harm'. 51, 53, 81, 96

It is unclear if an interim suspension issued under section 39 should trigger a section 35 notification. 53

Section 36 requires a practitioner to hold a current APC before a competence review can be conducted. Competence reviews should be allowed before issuing an APC. It is proposed that the words 'and who holds a current practising certificate' be deleted. 24, 51, 53, 106, 108

Section 36(4) should be deleted, and section 36(2) amended to list all grounds on which an authority can review a practitioner's competence, including becoming aware of relevant information from any source. 53

When reviewing competence under section 37, it is difficult to know when in the process the practitioner should be heard. This uncertainty is being exploited by lawyers and is potentially costly. Section 37 should be amended to specify that a practitioner may make a submission at the time the RA considers a report from a Competence Review Panel. 24, 43, 53

Section 38(1) should be amended to allow RAs to make an order preventing a practitioner from doing something – ie, prescribing. 53

Section 38(3) should be amended from 5 working days to 10 working days. 43

It is unclear what the words 'in association with' mean in section 38(3). Does this include DHBs with whom a practitioner has an access agreement with? It is suggested that the words 'any organisation with which the practitioner has an agreement relating to the conduct of that practitioner's practice' be used. 53

Section 39 should include a provision (5)(c) that states 'the completion of the competence programme'. The test in this section is also too high; the test in section 95(1) should be applied instead. There should also be greater consistency in the language used in sections 39, 48, 50, 69 and 95. 24, 43, 53

Section 39 should be amended to lower the threshold from 'serious risk of harm' to 'risk of harm', and to provide for interim suspensions without allowing the practitioner a chance to make a submission. 4, 5, 7

In section 40, the requirement for a current APC is again problematic. It should also be specified that the RA pays for competence reviews and that the practitioner pays for competence programmes. 24

Section 40(3) should include an additional subsection allowing an RA to require completion of any other activity deemed appropriate, or requiring a practitioner to undertake an approved peer review process. 53

Sections 40 and 41 should explicitly include CPD activities within their definition. 52

The requirement in section 41(6) to notify every practitioner after a recertification programme is set is costly. The section should be amended to require publication of the programme, but should allow the authority to use its discretion as to how that is achieved. This process should also apply to changes to an existing recertification framework. 53

Section 42 specifies that an authority may have access to hospital patient records in the event of a competence review. The requirement under section 42 should be extended to all health care providers. This requirement should override the Privacy Act 1993. 53

Section 43(1) should be amended to allow a practitioner's scope to be changed **and** conditions to be placed on practice. Currently, it only allows one or the other. 43

Section 45(5) should also allow hospitals, where students are often trained, to notify of concerns about students in the same way as training institutions can – namely, to notify of concerns that a student may not be able to practise in the profession. This section should also enable training providers to notify the RA if they have concerns regarding conduct and competence matters. 41, 62, 82

Section 45 is triggered when a practitioner is unable to perform the functions required for practice. This provision could apply when the practitioner is intoxicated. The section

should be reworded to capture the true intent, ie, where a practitioner is incapacitated for a prolonged period such that their practice poses a risk of harm. 92

Sections 46 and 49 should not be limited to medical advice and examinations. 1, 24, 43, 110

Section 49(2)(a)(i) and 49(6) should be reworded to provide greater scope. It is often not possible to identify a single condition that may make the practitioner unable to perform the functions required to practise. 43

Sections 55 to 58 should be reviewed to either remove the 'responsible person' or remove the requirement that they be independent. The responsible person should at least be a member of the team within which the PQAA is taking place. 95

The reporting requirement in section 58(1) should be removed and programmes should be required to maintain their own documentation. 95

In section 64, a provision could be made for screening out frivolous or vexatious complaints. 24

Often RAs do not hear back from the Health and Disability Commissioner regarding the outcome of complaints that have been referred on. 108

In section 65, there is a lack of flexibility when the Health and Disability Commissioner refers a complaint. The RA is not permitted to determine the best option to address the complaint. The only option seems to be a PCC, which is expensive and not necessarily appropriate. Other mechanisms for dealing with referrals, other than PCCs, should be provided for. It is also unclear if a PCC can be appointed where the Health and Disability Commissioner has closed a case, or where a case has not been investigated by the Director of Proceedings. 24

Section 68(2) requires referral of notice of conviction to a PCC, when such a matter could be considered by the RA or delegated to the registrar. 24

Section 69: It should be possible, in serious cases, to suspend and then hear the practitioner at the PCC. This power should be able to be delegated to subcommittees. 24

Section 69 should require RAs to take account of risk of harm. 106

At present, the wording in section 69 undermines section 34(2). Amend wording of section 69 to allow RAs to order interim suspension in instances where an investigation by the Health and Disability Commissioner is pending. 7

Section 71: Appointment of PCCs could be delegated to the RA's administrative arm, or a panel of candidates could be established and appointed by a subcommittee of the RA. 24

Section 72: Multiple opportunities for 'right to be heard' are costly and slowing down the process. Some practitioners are using these opportunities as a means to frustrate the business of the PCC. A balance between natural justice and pragmatism needs to be found. 24

Section 79 should reflect a standard of 'serious risk of harm', not 'risk of serious harm'. 24

Section 80 could allow PCCs to make determinations or recommendations regarding confidentiality and/or suppression. It could reflect the wording in section 59. 24

Section 89 (or Schedule 1, clause 5) should allow the Chair alone to make consent orders where agreement has been attained from both parties. 25

Section 94(3)(b) should allow the Tribunal full flexibility when considering a revocation of an APC; for example, the possibility of moving from outright suspension to the imposition of conditions. At present it only allows for the practitioner to apply for revocation of an interim order or interim conditions. 25

Section 94(3)(c) is unnecessary given section 157(4), and should be repealed. 25

Section 100 should allow for penalties in cases where a section 7 breach has occurred. 24

Section 100 should not be changed. 25

Section 101(1)(c) should be clarified to make it clear that the HPDT can independently impose conditions, whether or not an order of suspension is also imposed. 25

Section 102 should allow the Tribunal to fix a minimum time within which a practitioner may not apply for re-registration. 25

Section 103 requires the Tribunal's decisions to be fixed in writing before they can take effect. Decisions should be allowed to be given orally at a hearing, and confirmed as soon as possible in writing thereafter. 25
Section 103 should include a provision requiring RAs to give effect to any cancellations or conditions determined by the Tribunal. 25

Section 103 should include a provision allowing the Tribunal to notify an employer of the final decision of the Tribunal, as section 95(5) allows notification of an interim decision. 25

Section 104 should be clarified as to how the Tribunal should be resourced for operational issues. 25, 108

Section 106 should be amended to allow both parties to appeal all decisions of the Tribunal, not just the prosecution. 25

Section 106(1) should be amended to reflect that an order made under section 38 is limited to the authority's decision to impose a condition on the practitioner's scope of practice, and does not extend to an appeal against the conclusion reached about the practitioner's competence (*M E Gardner v Midwifery Council* 17 November 2006 CIV 2006-085-364). 51, 96

Section 118(j) should be amended to require RAs to liaise with other interested parties, such as employers and associations, over issues of common interest to the RAs. 37

Section 118 should require RAs to gather and receive data about the workforce, liaise with stakeholders, and promote awareness about the workforce. 51

Section 118 should recognise the ability of RAs to enter into voluntary agreements with practitioners; for example, where a practitioner may be fit to practise but may have a history of addiction and may agree to regular drug testing. 43

Section 120 should be amended to reflect the intent of Māori representation. 104

Section 120 should be amended to require that a majority of members of the RA be health practitioners 'regulated by that authority'. 104

Section 124 provides for the Minister of Health to audit RAs. It should also provide for the Ministry of Health to give advice to RAs in respect of section 13. 108

In section 130 the costs associated with programme accreditation are unique to that programme; therefore it is not possible to gazette just one fee. Provision for variable fees should be made, or no gazetting of fees should be required. 24

Section 131 should allow RAs to impose a levy in respect of costs associated with competence reviews. 24

Section 132 should be reworded to allow for issuing of an APC to be declined on the basis of an unpaid sum relating to a separate process, such as a competence programme. It is suggested that the words 'in respect of which that fee is payable' be removed. 43

Some practitioners hold qualifications over and above those necessary for registration, which are included under section 138(f). Section 149 does not allow for information held under 138(f) to be made public. It is suggested that section 138(b) be amended to allow for all qualifications held by a practitioner to be placed on the public register. 51, 81, 112

Section 144 should be simplified as revising the register, particularly in respect of 'dead addresses', is too resource intensive. It is suggested that section 144(4) be amended from a period of 6 months to a period of 3 months. The Medical Council should also be able to publish the names of the practitioners who have not paid their APC renewal or to transfer them to the non-practising register. A period of 10 working days from publication to removal would be suitable. 24, 43, 51, 53

Section 145 needs to allow for concerns about competence and not just fitness. 24

The scope of section 146 should be broadened to cover instances of a practitioner being registered on the basis of false information from a source other than the practitioner themselves. 106

Section 147 should cover New Zealand practitioners who have had action taken against them by an overseas authority. 43

Section 157 should state that an RA is permitted to inform overseas authorities of an order made by the RA. 43

Section 158 continues to allow substandard practitioners entry into New Zealand via the TTMRA. This legislation has been used to circumvent New Zealand's qualifications standards. A residency requirement should be imposed on practitioners wishing to use the TTMRA as a means of back-door entry into New Zealand. 24, 53, 64, 75, 81, 96, 98, 108

Section 171 should require the Act to be reviewed again in three years. 95

Section 174 should be amended to require a referral in respect of reproductive health services. 5, 6

Section 224(2) appears to pertain only to those programmes accredited under former legislation. It needs to be clarified. 106

Schedule 1, clause 6(5) should be amended so as to provide that the reference to the Tribunal in the definition of 'judge', in section 4 of the Evidence Act 2006, shall apply to the HPDT. 25

Concerning Schedule 1, the comments of the Supreme Court and Court of Appeal on clause 7 in (*CAC v MPDT* [2006] 3 NZLR 577 (SC; [2005] 3 NZLR 447 (CA)) should be considered. 25

Schedule 3 needs to clarify what happens to the requirement for layperson involvement when a power is delegated. 24

Powers of the Minister of Health

The Minister of Health should appoint the registrars as well as the RA members because of the wide-ranging duties/powers the registrar has under the Act. 2

There should be greater Ministry/Ministerial oversight of the way in which RAs operationalise the Act. 4

The Minister's powers should be reduced to ensure that there is no political interference in the decisions of the RAs. 23, 29

The Minister's powers should be clarified to the public and professions as to just what those powers are, and what they mean. 32

RAs should be free of ministerial interference. The Health and Disability Commissioner is an example. 55

The Minister's powers in respect of regulating new professions should be reviewed and clarified. 66

The Minister should have the power to audit compliance with the Act without limitation. 104

The Minister's power to direct resolution of disputes should be strengthened and clarified. 104

Part 7 of the Act: Miscellaneous provisions, consequential amendments and transitional provisions

Section 158 continues to allow substandard practitioners to enter and practise in New Zealand via the TTMRA, and has been used to circumvent New Zealand's qualifications standards. A residency requirement should be imposed on practitioners wishing to use the TTMRA as a means of back-door entry into New Zealand. 24, 53, 64, 75, 81, 96, 105, 108

A unilateral agreement with Australia to require international medical graduates to stay two years in New Zealand before obtaining the right to practise in Australia is a way to reduce the loss of skilled labour across the Tasman. This requirement could be worked into the TTMRA. 50

The TTMRA may allow practitioners to gain registration who, while clinically competent, may not be culturally competent. 5, 24

Reviews of the Act should be conducted every three to five years. 4

Some Australian councils take the position that only practitioners who are registered in New Zealand **and** hold a current APC are eligible for registration in Australia. Under the TTMRA, some RAs in New Zealand hold the view that registration is sufficient. Clarification of the TTMRA in respect of this issue is requested. 51

Suggested clarification or improvements

The difference between 'competence' and 'recertification' programmes needs to be clarified. 4, 24

The definition of public safety within the Act should be reconsidered. 28

The implication of the disciplinary procedures codified within the Act means that practitioners can face disciplinary action from both the RA and their employer. While the necessity for this situation is apparent, it is also possible that liaison between the employer, the union and the RA may reduce the number of cases referred to a PCC or the HPDT, as the employer may be able to discipline the practitioner. 37

The Act should allow an RA to refuse registration if the individual is found to have provided false documents, much like the provision in the Medical Practitioners Act 1995. 43

The Act should provide for registration of practitioners providing services from overseas to patients in New Zealand. 43

Section 45 should be the model against which all sections in the Act (dealing with competence, conduct and health) approach reporting. 43

Section 95 holds the most appropriate test, which should be applied throughout the Act to replace all other tests. 43

The Health Practitioners Competence Assurance Act 2003, the proposed amendments to the Health and Safety and Employment Act 1992, and the RA reporting criteria under the Injury Prevention, Rehabilitation, and Compensation Act 2001 all use the terms 'risk of harm', 'serious risk of harm' and 'risk of serious harm' in different ways. There should be consistency. 50

Other considerations about the operation of the Act

The Act does not provide for RAs to be concerned with workforce or employment issues, nor should it. The protection of the public and provision of best practice clinical care are the only valid concerns of the Act. The wording of the Act, particularly in respect of section 13, should reflect this focus. 1, 50

RAs and employers need to work more closely together to ensure each is discharging its obligations under the Act appropriately. Guidance needs to be developed for employers, practitioners and the public on their rights and obligations under the Act. 20, 37

The Act has imposed additional requirements on registered health practitioners, and these should be reflected by DHBs through a realignment of pay equity for professional staff within NGOs. This realignment should be done through the DHBs' multi-employer collective agreements. 26

RAs should be required to consider strategies supporting workforce availability when establishing competence and related requirements; such as how to support the sector's need for a flexible sustainable health workforce, and minimising costs to the sector of health practitioner regulation. 4, 28, 79

The Act is 'currently more constraining than enabling'. However, the causes of this status are acknowledged as likely to be that the Act has been in its initial stages, and, importantly, that the Act has the potential to encourage much greater flexibility. 28

A public education campaign or information strategy should be developed to increase the profile of the Act and its mechanisms. For example, it might use posters in a similar way to those used to raise awareness of human rights. 24, 29, 44, 80, 81, 99

The Act has established a two-tier workforce (regulated and unregulated). This structure has impacted negatively on collegial relationships in multidisciplinary teams. Unregulated people are not able to refer to themselves as ‘health practitioners’, and therefore unregulated roles are perceived as having lower status/value than regulated roles. 34

The issues around services provided to New Zealanders from outside New Zealand by unregistered people should be addressed in the Act. 52

The Act does not fit well with the Career Framework as it keeps professions in silos. 79, 85

The Ministry of Health needs to ensure that DHBs and PHOs are required to employ appropriate practitioners to carry out tasks that carry a safety risk to the public. 79

The Act should be amended to reflect a need for competence in sociocultural settings. 89

Appendix 2: Respondents to the Survey

Submission number	Respondent
1	New Zealand Association of Optometrists
2	Osteopathic Society of New Zealand
3	Psychologist
4	Optometrist
5	Federation of Women's Health Councils Aotearoa
6	Palmerston North Women's Health Collective
7	Health and Disability Commissioner
8	Optometrist
9	New Zealand Dental Therapists Association
10	New Zealand Institute of Dental Technologists Inc
11	New Zealand Dental Association
12	Clinical dental technician
13	South Link Health
14	New Zealand Register of Acupuncturists
15	New Zealand College of Midwives
16	Medical practitioner
17	Royal New Zealand Plunket Society (Inc)
18	Unknown
19	Family Planning Association of New Zealand
20	Mental Health Commission
21	New Zealand Institute of Medical Laboratory Science
22	Royal Australasian College of Surgeons
23	New Zealand Medical Association
24	Psychologists Board
25	Health Practitioners Disciplinary Tribunal
26	Platform
27	Aotearoa New Zealand Association of Social Workers
28	District Health Boards New Zealand
29	New Zealand Society of Physiotherapists Inc
30	Director, Primary Care Development, Counties Manukau DHB
31	Medical advisor, Wairarapa DHB
32	CHLabs
33	Joint Faculty of Internal Care Medicine
34	Programme Manager, Mental Health, Counties Manukau DHB
35	PHARMAC
36	Optometrist
37	New Zealand Public Service Association
38	Occupational therapists in Counties Manukau DHB
39	New Zealand Association of Orthodontists (Inc)

Submission number	Respondent
40	Nurses at Lakes DHB
41	Counties Manukau DHB
42	Pharmacy Industry Training Organisation
43	Medical Council of New Zealand
44	Director of Nursing, Counties Manukau DHB
45	Pharmacy Guild
46	Canterbury DHB
47	Health Professional Advisory Group, Specialist Mental Health Services, Canterbury DHB
48	National Heart Foundation Senior Fellow
49	School of Languages and Social Sciences
50	New Zealand Society of Anaesthetists
51	Pharmacy Council of New Zealand
52	Medical Laboratory Science Board and Medical Radiation Technologists Board
53	Midwifery Council of New Zealand
54	Registered nurse
55	Wellington Independent Practitioners Association
56	Dental technician
57	Occupational therapist
58	Mauora Taranaki PHO
59	Accident Compensation Corporation
60	Registration Manager
61	Drug and Alcohol Practitioners' Association Aotearoa-New Zealand
62	School of Health Science, Unitec New Zealand
63	Project officer, Primary Health Care
64	Institute of Clinical Psychology
65	Pathways
66	New Zealand Association of Anaesthetic Technicians
67	Capital & Coast DHB, Regional Mental Health Social Workers Network
68	Capital & Coast DHB, Mental Health Social Workers
69	Senior lecturer, Department of Human Nutrition, University of Otago
70	Rehabilitation, Older Persons and Allied Health, Hutt Valley DHB
71	Nutrition Services, Auckland City Hospital
72	Association of Salaried Medical Specialists
73	Director of Nursing & Clinical Services, Ashburton & Rural Health, Canterbury DHB
74	Royal Australian and New Zealand College of Psychiatrists
75	New Zealand Psychological Society
76	General practitioner
77	Counselling psychologist
78	Cardiac sonographer
79	New Zealand Dietetic Association
80	New Zealand Institute of Rural Health

Submission number	Respondent
81	Dental Council of New Zealand
82	College of Nurses Aotearoa (NZ)
83	New Zealand Association of Medical Herbalists
84	Institute of Counselling Psychologists
85	Allied Health Forum, Counties Manukau DHB
86	Ambulance New Zealand
87	Presbyterian Support Otago
88	Social Work Leaders Council, Waitemata DHB
89	New Zealand Association of Counsellors
90	New Zealand Dental Hygienists' Association
91	New Zealand Association of Psychotherapists
92	Medico-Legal Counsel, Auckland DHB
93	Optometrist
94	Medical practitioner
95	Australian and New Zealand College of Anaesthetists
96	Physiotherapy Board of New Zealand
97	New Zealand College of Clinical Psychologists
98	Clinical Psychologists Group, Otago DHB
99	Osteopathic Council of New Zealand
100	Royal New Zealand College of General Practitioners
101	Dietitian
102	DHB Psychology Leadership Council
103	Medical radiation technologist
104	New Zealand Nurses Organisation
105	Chiropractic Board
106	Nursing Council of New Zealand
107	New Zealand Association of Occupational Therapists
108	Optometrists and Dispensing Opticians Board
109	Psychologist
110	Psychologist
111	Dietitians Board
112	Pharmacist
113	TRG Group Ltd
114	Podiatrists Board

Appendix 3: List of Abbreviations

APC	annual practising certificates
CPD	continuing professional development
HPDT	Health Practitioners Disciplinary Tribunal
IPC	interim practising certificate
NGO	non-government organisation
PCC	professional conduct committee
PHO	Primary Health Organisation
PQAA	practitioner quality assurance activity
RA	responsible authority
TTMRA	Trans-Tasman Mutual Recognition Act 1997