

**Review of the Health  
Practitioners Competence  
Assurance Act 2003**

Report to the Minister of Health  
by the Director-General of Health

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# Executive Summary

## Chapter 1: Background

1. This review of the Health Practitioners Competence Assurance Act 2003 fulfils the requirements of section 171 of the Act. The requirement to review the Act after it had been operating for three years reflected Parliament's concerns that it was new, untested and was broad overarching legislation that left much of the implementation and operational aspects to regulation.
2. The review started in October 2007 and involved surveys, a commissioned paper looking at international best practice, and two rounds of meetings and workshops with stakeholders. This report draws together its findings.
3. The Act brought all regulated health professionals under a single piece of legislation, ending the previous regime in which they were regulated under 11 separate Acts. It prohibits unregistered people from implying that they are registered. It restricts some more dangerous activities to certain registered practitioners. The Act provides for the regulation of new professions.
4. Authorities have been established to be responsible for each health profession. These authorities are responsible various functions including:
  - describing their profession(s) in terms of one or more scopes of practice with associated qualifications
  - registering and issuing annual practising certificates to practitioners who have shown continuing competence
  - reviewing and promoting ongoing competence
  - considering cases of practitioners who may be unfit to practise
  - setting standards of clinical competence, cultural competence and ethical conduct
  - establishing professional conduct committees to investigate practitioners in certain circumstances.
5. A separate Health Practitioners Disciplinary Tribunal hears and decides on more serious charges laid against practitioners.
6. The Minister of Health calls for nominations and appoints members of responsible authorities. He or she has the power to remove members in certain circumstances, audit authorities, ask for information, and intervene in any dispute about overlapping scopes of practice.

## **Chapter 2: Overall conclusions**

7. Overall the review finds that, three years after it came into force, the Act is operating as intended and needs little legislative change. Three years, however, is a fairly short timeframe from which to judge the effectiveness of such a major change. A central recommendation is that the Ministry of Health arranges for the collection of stronger evidence to inform a further review of the policy settings as well as the operation of the Act in 2012.
8. The chapters in this report focus on the main ways the operation of the Act could be improved to protect the health and safety of the public and to enable strong future development of the health workforce.
9. Recommendations are made throughout the report. The complete list of 37 recommendations follows this executive summary. Those 17 recommendations that require legislative amendment are highlighted. All of the recommended amendments are technical and relate to operational aspects of the Act. It is the view of both the Ministry of Health and Parliamentary Counsel that all of these amendments may be made in the next Statutes Amendment Bill rather than requiring a separate amending Bill.

## **Chapter 3: Communication and engagement for stakeholders**

10. The effectiveness of the Act depends upon the existence of a good understanding of it among the public and key stakeholders and good communication between responsible authorities and other parties. Responsible authorities and the Ministry of Health all have a role in informing the public and improving the information available about the Act and about regulated practitioners.
11. Good communication and consultation among authorities, funders, employers, educators, policy-makers and other key stakeholders are important. In particular, these parties need to confer on scopes of practice and other matters that are crucial to the future workforce, as well as on protecting public health and safety.
12. Communication between authorities and the professions for which they are responsible works well generally but not universally. Issues about the membership of authorities and the appointment of their members are dealt with in Chapter 5. Authorities need to communicate openly and clearly to maintain the confidence of their professions.

## **Chapter 4: Collaboration among responsible authorities**

13. There is a lot to be gained by increased co-operation among responsible authorities, and their co-operative activities are already growing. Areas where authorities could learn from each other to develop the best ways of fulfilling their roles include:
  - establishing and reviewing scopes of practice
  - accrediting educational institutions and programmes
  - registering practitioners including overseas-trained applicants

- issuing annual practising certificates
- reviewing and promoting competence
- implementing recertification programmes
- managing practitioners who may be unable to practise because of illness
- setting standards for clinical and cultural competence and for ethical conduct.

## **Chapter 5: The Ministry of Health's role**

14. The Ministry of Health is the government department that administers the Act. It has an important role in enforcing the Act. It should make it widely known that it will prosecute breaches of the Act where it cannot otherwise gain compliance or where there is significant risk to public safety.
15. The Ministry acts as the Minister of Health's agent for appointments to responsible authorities. Processes for defining what is needed, identifying good nominees and assisting the Minister to make good choices should be improved. Opinions are divided over whether elections should play a part in appointments, for that reason the Minister's current power to regulate elections on a case-by-case basis should continue.
16. The Ministry should continue to administer the list of restricted activities. At this stage, no new activities are proposed. The restricted activity concerning psychosocial interventions is not effective and impairs the delivery of some safe services; it should be revoked.
17. The Ministry should expand its role of oversight of the effectiveness of the Act. Its expanded role should include setting measures for responsible authorities' performance and establishing stronger processes for reporting and collecting higher-quality information. In the light of their importance for the future health workforce the Ministry needs to continue to build strong relationships with all stakeholders involved with health professional regulation.

## **Chapter 6: Extension of the Act to further groups of practitioners**

18. Over 25 new groups of health-related service providers have indicated that they wish to be regulated under the Act. Criteria have been developed for considering new health services for regulation; these should be improved to more clearly define which services should be regulated.
19. There is a range of reasons why persons providing services affecting the health of the public may seek to be regulated, which are often not related principally to the need to protect the public. Status, legitimacy, competitive advantage and the hope of being recognised for public funding may be relevant. The principal purpose of the Act, however, is to protect the health and safety of the public. Where regulation is recommended, costs can be reduced by combining professions under one authority or by having separate authorities that share infrastructure costs. There is also currently no power to amalgamate or restructure existing authorities even when authorities wish to join and it is in the public interest to do so.

## **Chapter 7: Complaints and disciplinary matters**

20. The Act aimed to put in place consistent, co-ordinated, fair and transparent processes for handling complaints against health practitioners, and those processes had to integrate with the Health and Disability Commissioner Act 1994. This has largely been fulfilled. A number of relatively minor, technical legislative amendments are proposed to ensure that the Act operates in all respects as Parliament intended. These are outlined in detail in the paper.

## **Chapter 8: Protected quality assurance**

21. The Act enables the Minister to confer protection on quality assurance activities conducted to improve the practices or competence of health practitioners. By this means, the Minister can protect the confidentiality of information that becomes known solely as a result of those activities and give those engaged in those activities immunity from civil liability.
22. A number of clarifications and changes are recommended to make these provisions work better. The provisions for appointing people who will be responsible for quality assurance activities should be modified so that these people need not be independent from the activity – though they often will be in large institutions. Reporting requirements should be simplified so that reports can focus on showing that protecting the activity continues to be in the public interest rather than attempting to collect detailed information about outcomes as well.

## **Chapter 9: Other issues for consideration**

23. Chapter 9 picks up on a number of proposed changes that are not covered in earlier chapters. The interpretation section should clarify that 'emergency' includes an ongoing emergency such as a pandemic. There is a discussion and recommendation on how some responsible authorities may be judging an applicant's fitness for registration on matters that were strictly not intended by the legislation. A number of areas may require clarification as to the intent of the Act.

# List of Recommendations

**Note:** Those recommendations that require legislative change are shaded.

## Chapter 2: Overall conclusions

**Recommendation 1:** That it is noted that the Health Practitioners Competence Assurance Act 2003 is currently operating largely as intended, and that the Director-General of Health is instructed to carry out a further review of the Act starting in 2012 (page 11).

## Chapter 3: Communication and engagement for stakeholders

**Recommendation 2:** That responsible authorities and the Ministry of Health do more to inform the public about the Health Practitioners Competence Assurance Act 2003 through their websites, publications and other means – including making information about registered practitioners freely available (page 13).

**Recommendation 3:** That responsible authorities improve the processes around scopes of practice including developing a set of principles and guidelines, regular review, a central web-based point for notifying new consultations, and processes to allow any interested party to propose new or amended scopes (page 14).

**Recommendation 4:** That responsible authorities consult on and take account of the health services impact of their decisions and carefully weigh these up against considerations of public safety and, where appropriate and safe, they consider using the power they have under section 21 of the Act to authorise scopes of practice for individual practitioners (page 15).

**Recommendation 5:** That responsible authorities, mindful of the impact of practitioner fees on the health care system, try to restrain cost growth, look for ways to make efficiencies, minimise fee increases, and openly explain the basis for their fees and any increases (page 15).

## Chapter 4: Collaboration among responsible authorities

**Recommendation 6:** That responsible authorities work together and with Australian counterparts to identify and share best practice principles and arrangements for accreditation of educational institutions and programmes and that the Ministry of Health gives further policy consideration to developing a Trans-Tasman joint accreditation system for regulated professions (page 19).

**Recommendation 7:** That responsible authorities should collaborate with the Ministry of Health and Australian authorities to develop risk-based standards, processes and assessment models to be used for assessing overseas-trained practitioners (page 20).

**Recommendation 8:** That responsible authorities actively explore ways in which they can share with and learn from other authorities in order to improve quality and, where possible, reduce costs (page 25).

## **Chapter 5: The Ministry of Health's role**

**Recommendation 9:** That the Ministry of Health consults with responsible authorities and any other interested stakeholders about the processes for appointing members to responsible authorities and to the Health Practitioners Disciplinary Tribunal panel, and develops a set of criteria and competencies to help ensure the best appointments are made (page 31).

**Recommendation 10:** That section 120(4) of the Health Practitioners Competence Assurance Act 2003, which gives the power to have some members of responsible authorities elected, should remain unchanged and the question of whether to allow elections should continue to be considered on a case-by-case basis (page 34).

**Recommendation 11:** That the restricted activity concerning psychosocial interventions be revoked by Order in Council (page 36).

**Recommendation 12:** That the Ministry of Health arranges for a set of indicators to be developed in consultation with responsible authorities and other interested stakeholders to measure the effectiveness of the Health Practitioners Competence Assurance Act 2003 and to measure the performance of responsible authorities (page 37).

**Recommendation 13:** That the Ministry of Health consults with responsible authorities and other interested stakeholders to establish a standard template for authorities' annual reports and standard information to accompany notices of scopes of practice and fee changes (page 37).

**Recommendation 14:** That, as part of national workforce planning, the Ministry of Health works with responsible authorities and other stakeholders to improve the collection, collation, analysis and dissemination of comprehensive, accurate, comparable, timely and non-identifiable information about the registered health practitioner workforce and advises the Government as to whether any increase in resources or legislative change is required to make those improvements (page 38).

## **Chapter 6: Extension of the Act to further groups of practitioners**

**Recommendation 15:** That the Ministry of Health examines and consults on criteria for statutory regulation of unregulated health occupations with reference to criteria such as those proposed for Australia (page 42).

**Recommendation 16:** That section 114 of the Health Practitioners Competence Assurance Act 2003 is amended to give the Minister the power by Order in Council to join and restructure two or more existing authorities in situations where, after consultation, the Minister is satisfied that it is in the public interest to do so and that the authorities and their professions are generally in agreement (page 47).

**Recommendation 17:** That the Ministry of Health reviews the process for groups seeking to have a new health service regulated as a profession in order to gather full information with which to advise the Minister of Health as to whether statutory occupational regulation is recommended and, if so, what arrangements are best for appointing a responsible authority in respect of that profession (page 47).

**Recommendation 18:** That, after this report has been tabled in the House of Representatives, the Ministry of Health moves rapidly to make recommendations to the Minister of Health in respect of those groups for which it has already been decided that statutory regulation under the Health Practitioners Competence Assurance Act 2003 is appropriate (page 48).

## Chapter 7: Complaints and disciplinary matters

**Recommendation 19:** That sections 64 and 118 of the Health Practitioners Competence Assurance Act 2003 are amended to specifically recognise that it is a function of responsible authorities to receive complaints about the appropriateness of a practitioner's conduct and to protect complainants against civil or disciplinary proceedings unless they have acted in bad faith (page 50).

**Recommendation 20:** That section 68(2) of the Health Practitioners Competence Assurance Act 2003 is amended to give responsible authorities discretion whether to refer practitioners who have been convicted under a minor offence listed in section 67(b) to a professional conduct committee (page 51).

**Recommendation 21:** That sections 69 and 93 of the Health Practitioners Competence Assurance Act 2003 is amended to restrict interim suspension to situations where there are reasonable grounds to believe that a practitioner's conduct poses a risk of serious harm to the public (page 51).

**Recommendation 22:** That paragraph 17 of Schedule 3 to the Health Practitioners Competence Assurance Act 2003 is amended to allow the responsible authority to delegate any of its functions, duties or powers to a committee or to its Registrar (page 53).

**Recommendation 23:** That section 95 of the Health Practitioners Competence Assurance Act 2003 is amended to allow the Chair of the Health Practitioners Disciplinary Tribunal to issue, on his or her own, an order for non-publication of material in circumstance where all parties to a hearing consent to the non-publication order (page 54).

**Recommendation 24:** That section 102 of the Health Practitioners Competence Assurance Act 2003 is amended to enable the Health Practitioners Disciplinary Tribunal to set a minimum period before which a health practitioner whose registration has been cancelled cannot apply for re-registration (page 55).

**Recommendation 25:** That section 103 of the Health Practitioners Competence Assurance Act 2003 is amended to give the Health Practitioners Disciplinary Tribunal the power to instruct the appropriate executive officer of the Tribunal to notify any employer of orders of the Tribunal if the Tribunal is satisfied that such disclosure is in the public interest (page 55).

**Recommendation 26:** That section 6(5) of Schedule 1 of the Health Practitioners Competence Assurance Act 2003 is amended to bring it into line with the repeal of the Evidence Act 1908 and the enactment of the Evidence Act 2006 (page 56).

**Recommendation 27:** That section 104 of the Health Practitioners Competence Assurance Act 2003 is amended to clarify that responsible authorities are responsible for paying running costs of the Health Practitioners Disciplinary Tribunal, including costs not directly related to individual hearings and the costs of training tribunal panel members (page 57).

## Chapter 8: Protected quality assurance

**Recommendation 28:** That section 55(3)(a) of the Health Practitioners Competence Assurance Act 2003 is amended so that a person responsible for quality assurance activities is not required to be independent of the activity (page 62).

**Recommendation 29:** That section 58 of the Health Practitioners Competence Assurance Act 2003 is amended to simplify and reduce the administrative burden of the reporting requirements for quality assurance activities (page 63).

**Recommendation 30:** That District Health Boards review their provisions for protected quality assurance activities and apply for any necessary amendment to the relevant regulation so that, where appropriate, the regulation covers information from all practitioners involved in the activity, whether or not these practitioners are employees or independent practitioners (page 64).

**Recommendation 31:** That the Ministry of Health and the Quality Improvement Committee consider research into the value and use of protected quality assurance activities (page 64).

## Chapter 9: Other issues for consideration

**Recommendation 32:** That a definition is added to section 5 of the Health Practitioners Competence Assurance Act 2003 so that it is clear that the term 'emergency' includes prolonged emergencies such as a pandemic (page 65).

**Recommendation 33:** That section 12 of the Health Practitioners Competence Assurance Act 2003 is amended to clarify that responsible authorities have the power to revoke an educational institution's accreditation (page 66).

**Recommendation 34:** That section 15 of the Health Practitioners Competence Assurance Act 2003 is amended to give responsible authorities the power when necessary to recognise New Zealand qualifications as equivalent to qualifications that have been prescribed under section 12 (page 66).

**Recommendation 35:** That the Ministry of Health works with responsible authorities to clarify the intention of section 16 of the Health Practitioners Assurance Act 2003 when judging fitness for registration (page 67).

**Recommendation 36:** That section 17(4) of the Health Practitioners Competence Assurance Act 2003 is amended to include fines and costs imposed on practitioners by disciplinary findings under the relevant former legislation on professional registration (page 67).

**Recommendation 37:** That section 49 of the Health Practitioners Competence Assurance Act 2003 is amended to allow a responsible authority to require an examination by a medical practitioner or another appropriate health practitioner (page 69).

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# Chapter 1: Background

- 1.1 This chapter provides background to the Review of the Health Practitioners Competence Assurance Act 2003. It outlines the approach to health professional regulation in New Zealand and elsewhere. It describes the key features of the Act and gives a context for understanding how the Act is working.

## Purpose and process of the review

- 1.2 The Health Practitioners Competence Assurance Act 2003 came into force on 18 September 2004. The Act contained a number of new provisions, some of which were at the time untested and controversial, particularly for some health professions. On the recommendation of the Health Select Committee, Parliament agreed that the Director-General of Health should review the Act's operation after three years and that the Minister of Health would report the findings to the House of Representatives. The provisions for the review were included as section 171 of the Act.

### **171 Review of operation of Act**

- (1) As soon as practicable after the expiry of the period of three years beginning on the commencement of this section, the Director-General of Health must –
    - (a) review the operation of this Act since the date of the commencement of this section; and
    - (b) consider whether any amendments to this Act are necessary or desirable; and
    - (c) report the findings of the Director-General of Health to the Minister.
  - (2) As soon as practicable after receiving the report, the Minister must present a copy of that report to the House of Representatives.
- 1.3 Section 171 requires the Director-General of Health to review the operation of the Act not the policy underpinning it. Section 171(1)(b), however, asks the Director-General to consider whether amendments to the Act are needed.
- 1.4 In addition to the mandate given in section 171, in March 2007 Cabinet specifically asked that the review address 'the proliferation of registration authorities'.
- 1.5 A review of this nature needs to give all stakeholders opportunities to comment on how the Act is working and contribute to proposals for change. Stakeholders first were asked to comment on the design and Terms of Reference for the review,<sup>[1]</sup> which were subsequently approved by Cabinet and published.<sup>[2]</sup> The full Terms of Reference are included in Appendix 1. They state that:

the review will focus on the way in which the Act is being operationalised to achieve its intent to protect the public. The Ministry will initially identify significant operational areas for review. However, those who wish to participate in the review will be welcome to comment on any other operational aspect of the review they wish to.

- 1.6 There have been three phases to the review. The first phase was information gathering. A survey document was distributed to interested parties.<sup>[3]</sup> In total, 114 responses were received. The Ministry of Health published an analysis of responses along with the verbatim responses of those who agreed to publication.<sup>[4]</sup> In addition, 963 registered health practitioners completed an online survey of their experiences of how the Act is operating and the findings were published.<sup>[5]</sup> The Ministry also commissioned a report into best practice in health workforce regulation, both in the New Zealand environment and internationally.<sup>[6]</sup>
- 1.7 In the second phase, open workshops were held during April 2008. Participants helped develop proposals for change in the light of the findings from the first phase. Workshops were held in Auckland, Wellington and Christchurch and attended by about 250 participants. Meeting notes were subsequently published.<sup>[7-9]</sup>
- 1.8 The third phase of the review involved further workshops during September and October 2008. The Ministry presented findings and explained recommendations for the final report. These workshops replaced the discussion document consultation process that had been initially planned. Three workshops were held and attracted a total of about 200 participants. A separate meeting was held on the quality assurance provisions. In addition, meetings were held for responsible authorities and District Health Boards. Participants were invited to submit written comments on the presentation of proposals.
- 1.9 As a result of these processes, the review has been informed in writing and orally by many stakeholders including responsible authorities established under the Act, District Health Boards, other health care funders and providers, primary health organisations, health professional colleges and associations, health worker unions, educational institutions, consumer organisations, the Health and Disability Commissioner and a significant number of individual health workers and members of the general public. Appendix 2 lists organisations that made submissions or took part in meetings.

## **New Zealand health professional regulation – purposes and approaches**

- 1.10 The Ministry of Economic Development's statutory framework for government agencies states that regulation of occupations has the broad aim to 'protect the public from the risks of an occupation being carried out incompetently or recklessly'.<sup>[10]</sup> The framework further states that:

intervention by government in occupations should generally be used only when there is a problem or potential problem that is either, unlikely to be solved in any other way, or inefficient or ineffective to solve any other way. The amount of intervention should be the minimum required to solve the problem and the benefits of intervening must exceed the costs.

- 1.11 The involvement of government is not the only way that the public can be protected from occupational harm or risks. In many industries, workers and service providers self-regulate by way of codes of practice or voluntary accreditation schemes. It is then left up to people to decide whether or not they choose a service that is part of that industry self-regulation. Traditionally health professions were self-regulated in this way but over time in most countries governments have introduced legislation covering initially the medical profession and later other professions. However, self-regulation is still appropriate where the costs and benefits do not justify statutory regulation (see further discussion in Chapter 6).
- 1.12 Government also has various mechanisms, apart from occupational regulation by statute, by which it can protect the public from harm and ensure the quality of health services. For example, a government can provide information about services, can be involved with funding or assessing training, can set and enforce standards or, as a funder or employer of service, can specify standards for service delivery or for those who provide the service.
- 1.13 In New Zealand safety and quality of health services are regulated under a number of different Acts. Among these laws are the New Zealand Public Health Act 2000 (which sets up the Quality Improvement Committee), the Health and Disability Services (Safety) Act 2001 and the Medicines Act 1981.
- 1.14 Prior to 2003 health professionals were mostly regulated by certification. That is, only those practitioners who met certain requirements were certified to use particular titles, abbreviations, badges or uniforms signifying their particular profession or to otherwise 'hold themselves out' to be practitioners of a particular kind.
- 1.15 In a few cases a licensing approach was used: only dentists were permitted to practise dentistry, only optometrists could practise optometry and only dispensing opticians could practise optical dispensing. The occupations of dental technician, medical laboratory technologist, medical radiation technologist, and podiatrist were defined as 'registrable occupations' in which only appropriately registered practitioners could engage.

## **International approaches**

- 1.16 Most countries now regulate health practitioners by statute. In doing so, however, they take a variety of approaches. They also apply those regulations to a range of different professions. For example, new Australian legislation – due to be introduced from 2009 by way of similar statutes in each state – will regulate nine occupations. In the United Kingdom 35 professions are statutorily regulated.
- 1.17 Most countries use a certification approach (protection of title) but some license particular tasks or practitioners. Increasingly countries have introduced regular recertification with revalidation of continuing competence.

- 1.18 The balance between government and professional self-regulation varies considerably. Some countries have laws that recognise and mandate professional self-regulation; for example, the Norwegian Medical Association is empowered to regulate doctors in that country. In other jurisdictions, such as most states of the United States, the professional regulation mechanisms are an integral arm of the executive of the state government.

## History of the Act

- 1.19 The Act replaced 11 earlier statutes, the oldest of which dated back to 1949 (see Appendix 3). The Act was based on the Medical Practitioners Act 1995, at that time the most recent regulatory statute for health professionals. The design of the 1995 Act had been influenced by a number of high profile cases – notably the Cartwright Inquiry into Cervical Cancer – that had prompted debate about the governance, accountability and ethics of the medical profession. Under the Medical Practitioners Act professional self-regulation was somewhat reduced. It gave the Medical Council more lay members and a majority of appointed members, provided for discipline to be managed by a separate disciplinary tribunal, and protected designated quality assurance activities.
- 1.20 New or different aspects of the 2003 Act included scopes of practice, the removal of elections for appointing professional members of responsible authorities, and changes to quality assurance provisions. There was a further small shift away from self-regulation. As well as appointing members the Minister of Health has the power under certain circumstances to remove members, can audit authorities and can intervene in respect of scopes of practice that overlap between authorities.
- 1.21 In its 2003 report on the Health Practitioners Competence Assurance Bill, the Health Select Committee<sup>[11]</sup> noted that the Bill was:
- intended to provide a framework for the regulation of health practitioners in order to protect the public where there is a risk of harm from the practice of the profession. It includes mechanisms to assure the public that a registered health practitioner is competent to practise. It also includes consistent procedures across the professions for handling complaints against health practitioners, co-ordinated with the provisions of the Health and Disability Commissioner Act 1994. It is intended to provide a positive and professional working environment, where complaints can be dealt with in an open and transparent manner.

## Key features of the Act and a brief description of its parts

- 1.22 The Act brings all regulated health professions under one piece of legislation to consistently achieve its principal purpose. That purpose is to protect the health and safety of members of the public by providing mechanisms to ensure health practitioners are competent and fit to practise their professions.

- 1.23 In its report the Health Select Committee<sup>[11]</sup> noted that the Act balances ‘the demands of public safety against allowing practitioners sufficient involvement in the regulation of their profession’. The committee noted that some health professionals had concerns about ‘a move away from professional self-regulation to statutory regulation with increased ministerial powers while consumer groups are concerned that there would be too much power for health practitioners’.
- 1.24 The Act is largely based on certification of title rather than licensing of activity. It prohibits those who are not registered as health practitioners of a profession from claiming or implying to be practitioners of that profession. Apart from a limited number of specified restricted activities where there is risk of serious or permanent harm, the Act does not prohibit unregistered people from performing activities that registered health practitioners perform. These provisions are in Part 1 of the Act.
- 1.25 Authorities are established under the Act to be responsible for registration and oversight of practitioners of a particular profession or professions (see Appendix 4). Each responsible authority has to describe its profession(s) in terms of one or more scopes of practice and has to prescribe qualifications for every scope of practice. Health practitioners must work within their scope of practice when performing a health service that is part of their profession. Scopes of practice may overlap between different professions.
- 1.26 Authorities register practitioners and issue annual practising certificates. Registered practitioners must have the prescribed qualifications, be competent to practise within their scope and meet certain requirements to be fit for registration. An authority must not issue an annual practising certificate unless it is satisfied that the practitioner is competent. These provisions are covered in Part 2 of the Act.
- 1.27 Part 3 of the Act provides mechanisms for improving competence and protecting the public from practitioners who are incompetent, or incapable because of ill health. These mechanisms include competence reviews, recertification programmes and protected quality assurance activities. There are provisions for reporting incompetent or unfit practitioners, and for interim suspension in certain circumstances.
- 1.28 Part 4 of the Act covers disciplinary matters. An authority can set up a professional conduct committee to investigate complaints referred to it by the Health and Disability Commissioner or situations where a practitioner has been convicted of certain offences. A separate single Health Practitioners Disciplinary Tribunal is established to hear and decide on charges that are brought before it by the Director of Proceedings or by a professional conduct committee. For a hearing the tribunal consists of three peer professionals, a layperson and the chairperson or deputy chairperson of the tribunal. The responsible authority for each profession is responsible for funding and supporting a tribunal hearing against a member of that profession.
- 1.29 Part 5 provides for appeals to the District Court against decisions of an authority and to the High Court for appeals against decisions of the Health Practitioners Disciplinary Tribunal.

- 1.30 Part 6 covers the responsible authorities: continuance of existing ones, establishment of some new ones, their stated functions, membership and other provisions. The Minister of Health is given powers to regulate additional health professions where the practice of the profession carries a risk of harm, or regulation is otherwise in the public interest. Authorities must have between five and 14 members, including two or three lay members (depending on the overall size), and a majority of health professional members. The Minister appoints authority members (and has a power to make regulations to allow a proportion to be elected). The Minister also has other powers related to audit and requiring information from authorities.
- 1.31 Part 7 contains miscellaneous provisions (including the requirement for this review), transitional provisions and consequential amendments.

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## Chapter 2: Overall Conclusions

- 2.1 This chapter presents the overall finding that the Health Practitioners Competence Assurance Act 2003 is generally operating well and achieving its objectives and there is no reason to change its underlying policy settings or approach. The timeframe of three years, however, is too short to allow a full assessment of the Act's impact. On this basis, a recommendation of this review is that another review be conducted in a further three years. Some, largely operational improvements are needed. These issues are presented in subsequent chapters, with a focus on: communication (Chapter 3: ); collaboration (Chapter 4: ); a stronger role for the Ministry of Health as the government department administering the Act (Chapter 5: ); future extension of the Act to other professions (Chapter 6: ); complaints and disciplinary matters (Chapter 7: ); protected quality assurance provisions (Chapter 8: ); and a range of other issues raised in submissions (Chapter 9: ).

### Overall conclusions

- 2.2 The overall conclusion of the review is widely shared among health sector stakeholders. In identifying evidence of success, these stakeholders most often mention that health practitioners are now paying closer attention to competence and quality processes. Also cited are improvements in the management of complaints and the consistent, separate disciplinary process.

### The objectives of the Act

- 2.3 The Act objectives were outlined in a general policy statement as part of the explanatory note when the Bill was introduced to the House of Representatives in 2003.<sup>[12]</sup> That statement included the following objectives:
- ensure that appropriate occupational regulations are retained in the health sector
  - ensure regulatory statutes are flexible enough to allow health practitioners to vary their practice to meet new and challenging environments
  - assure the public that registered health practitioners are competent to practise
  - create a supportive environment in which health practitioners can practise, maintain their competence throughout their careers, and learn from their experiences and the experiences of their colleagues
  - improve the processes for complaints against health practitioners to ensure that they can be resolved expeditiously and fairly with adequate communication between the various government agencies involved.

- 2.4 The statement laid out the methods the Act would use to achieve these objectives:
- provide a uniform approach to all health professions, with changes applying automatically to all professions
  - be flexible enough to meet changing skill sets, roles, diagnostic regimes, and treatments
  - be transparent so that practitioners and the public can easily see which professions are regulated and how
  - provide a supportive environment for health practitioners to maintain their competence
  - provide a process for new professions to be regulated under the Act by Order in Council
  - provide consistent, co-ordinated, fair and transparent processes for handling complaints against health practitioners.

### **Overall findings against objectives**

- 2.5 **Retaining appropriate occupational regulations in the health sector.** In addition to those professions that were regulated previously, the Act added osteopathy as a newly regulated profession and has separated the regulation of midwifery from nursing. The review finds that occupational regulation by statute continues to be appropriate for all these professions.
- 2.6 **Flexibility in the regulatory statute.** The Act allows responsible authorities considerable flexibility in how they approach their functions. Some authorities are supporting new ways of working, for example, by developing new scopes of practice. Concerns, however, have also been voiced – for example, that some approaches to defining scopes of practice may be introducing workforce rigidity rather than flexibility (see paragraph 3.9 below). These concerns are of particular importance since, like other countries, New Zealand faces increasing workforce demands and needs to be able to have workforce flexibility to support innovative approaches to service delivery.
- 2.7 **Assuring the public that practitioners are competent.** Members of the public as well as employers and others now have access to information about who is a registered practitioner in each of the responsible authorities. The authorities all now have processes to ensure they do not register a practitioner who has failed to maintain a required standard of competence. In general these processes appear to be operating as intended. For some professions the ongoing competence provisions are new and, although they have imposed new costs on practitioners and the system generally, there is a widespread acceptance that they have brought significant benefits in terms of public safety and quality.

- 2.8 **Creating an environment supporting quality improvement.** Attention to ongoing quality among professional groups has increased since the Act was implemented. This improvement is particularly marked with professions other than medicine, given that medicine already had recertification processes in place under the Medical Practitioners Act 1995. That 1995 Act also included provisions to protect quality assurance activities and the Health Practitioners Competence Assurance Act 2003 widened the application of those provisions to professions other than medicine. Professionals who use these provisions value them, although some adjustments are needed (see Chapter 8: ).
- 2.9 **Improving the process for complaints against practitioners.** The Act brought consistency to the way that complaints against health practitioners are dealt with and linked this Act to the processes under the Health and Disability Commissioner Act 1994 (which was amended accordingly at the time this 2003 Act was passed). These changes are working well although there is room for responsible authorities to learn from each other about how best to manage complaints and the processes around professional conduct committees. Recommendations for improving the detailed provisions for reporting and dealing with concerns are given in Chapter 7: .
- 2.10 **A uniform approach for all professions.** The Act has provided a single and consistent legislative approach for all regulated professions. Although at the time that Parliament was considering the Bill there were calls to exclude medical practitioners,<sup>[13]</sup> the inclusiveness of the Act is now widely welcomed and is something that few countries have achieved. The changes it has brought for some professions have been quite significant, and professions as well as their responsible authorities are still learning and developing full capabilities. Recommendations to improve consistency of approach and to encourage authorities to adopt best regulatory practices are given in Chapters 3 and 4 on communication and collaboration respectively.
- 2.11 **Flexibility to meet changing needs.** The Act gives considerable autonomy and power to responsible authorities and allows them flexibility in most of their functions. This is another area where authorities are still learning how best to use their powers. Attention needs to be paid to balancing the need for workforce flexibility with the principal requirement to protect public health and safety. This area for improvement is further discussed in later chapters.
- 2.12 **Transparency for the public and practitioners.** The Act requires authorities to make their registers publicly available, to publish scopes of practice and fees in the Parliamentary Gazette and to table their annual reports in Parliament. There are requirements for consultation when authorities are considering changes to scopes of practice. There is considerably more openness in respect of disciplinary hearings and complaints processes than there was under earlier legislation. In general the review finds that these aspects of the Act are operating well although improvements in a number of areas are recommended in later chapters.
- 2.13 **An environment supportive of maintaining competence.** As noted in paragraph 2.8 professional groups are paying closer attention to maintaining competence and in general the environment is supportive of this key activity.

- 2.14 **New professions able to be added by Order in Council.** The Minister of Health has once used powers under section 116 of the Act to recommend designating another health service – psychotherapy – as a health profession. Consultation about regulating a number of other health services providers has taken place but the process has been slow. Cabinet instructed that this review should deal with the question of the proliferation of registering authorities, which effectively put on hold any further recommendations for new practitioner groups pending the outcome of the review. Recommendations about this issue are made in Chapter 6: .
- 2.15 **Consistent and fair complaints process.** As noted in paragraph 2.9, the new complaints process with its close links to the Health and Disability Commissioner appears to be working well. Later chapters will recommend some improvements in its operation and some adjustments to the related legislative provisions.

### **Need for further review**

- 2.16 As set out under the Act, this review began just three years after the Act came into force. The implementation of the Act involved a major change for most professions and their responsible authorities. In addition, three years is a short timeframe from which to be able to judge a change of this magnitude. The system is still developing, authorities are still changing, and processes are improving.
- 2.17 The following are examples of changes that have occurred during the course of the review.
- Five authorities have joined forces to share premises and systems.
  - All 16 authorities have signed a memorandum of understanding to work together as Health Regulatory Authorities of New Zealand (HRANZ).
  - HRANZ and some individual authorities have recently established regular meetings to discuss issues with District Health Boards.
- 2.18 Although the review's overall finding is that the Act is operating as intended, in truth it is difficult to judge its success conclusively. There is little consistent evidence upon which to base a judgement of effectiveness. The highest-profile case relating to health professional regulation since the Act came into force has been that of Dr Roman Hasil in Wanganui. In regard to that case, the Health and Disability Commissioner's report<sup>[14]</sup> found some matters to improve in terms of registration and oversight but nothing that challenged the legislative framework for health professional regulation.
- 2.19 In Chapter 5: this review recommends a stronger oversight role for the Ministry of Health. In addition, however, and mindful of the policy changes being made in other jurisdictions, the review recommends a further review in another three years. The next review should explicitly address the policy settings as well as the operation of the Act.

**Recommendation 1:** That it is noted that the Health Practitioners Competence Assurance Act 2003 is currently operating largely as intended, and that the Director-General of Health is instructed to carry out a further review of the Act starting in 2012.

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## Chapter 3: Communication and Engagement for Stakeholders

- 3.1 This chapter is about the critical importance of good communication and engagement in making the Health Practitioners Competence Assurance Act 2003 work well. Most authorities are taking their responsibilities seriously, particularly in respect of their principal purpose of protecting public safety. There is, however, room for improvement in a number of areas.

### Public awareness

- 3.2 The Act relies on protection of title rather than on giving practitioners exclusive rights to undertake particular practices. Apart from the few restricted activities, unregistered people are allowed to do what a registered practitioner can do. This system leaves the public free to choose a registered practitioner – where they have assurance of competence – or an unregistered provider, without any such assurance. However, the system will only protect the public if people understand how it works and have easy access to registration information.
- 3.3 Authorities are required to publish their register of health practitioners either in print or in electronic form. All authorities make their register available electronically on their websites; all but two of them have online search and/or browse functions. Only half of the authorities, however, list a district for each practitioner and only three have chosen to include any more detailed information on addresses. Address information clearly helps the public when looking for practitioners. Section 149(2) of the Act explicitly confers the power to include address information unless the practitioner objects. This provision was added by a Government Supplementary Order Paper during the Bill's committee stages in the House so it is surprising that only one council has used the power to publish address information. One council mistakenly states on its website that it 'cannot give out personal details such as address's [sic] and telephone numbers for privacy reasons'.<sup>[15]</sup>
- 3.4 One of the explicit functions of the responsible authorities is 'to promote public awareness of the responsibilities of the authority'. Few authorities seem to have been very active in fulfilling this function. Fewer than half of the authorities' websites have a section that is clearly written for the public or the users of health services. Only a few of them list publications for members of the public. Websites could easily include information to promote public awareness of the authority's responsibilities. Moreover, those authorities that have not yet done so could be encouraged to borrow ideas from those that have.
- 3.5 The Ministry of Health, as the government department responsible for administering the Act, has an important role in helping to raise public awareness of how the Act works to protect the public. At the time that the Act began, the Ministry worked with responsible authorities to publish a pamphlet about the Act but little has been done since then. The Ministry's website gives information on the provisions of the Act but it is neither fully up to date nor presented in a way that is easily accessible to the general public. The Ministry should also take other opportunities to promote the Act publicly.

**Recommendation 2:** That responsible authorities and the Ministry of Health do more to inform the public about the Health Practitioners Competence Assurance Act 2003 through their websites, publications and other means – including making information about registered practitioners freely available.

## **Communication among authorities, employers, funders, educators, policy-makers and others on scopes of practice and other matters**

- 3.6 Health professional regulation is an important aspect of a country's workforce arrangements. Good regulation protects the public by ensuring that employers, particularly publicly funded employers, use safe and competent practitioners. Under New Zealand's Act, the authorities are also responsible for accrediting educational institutions and recognising qualifications – both essential components for ensuring the supply of well-qualified practitioners.
- 3.7 The health workforce challenges facing New Zealand now and into the future will require not only more health practitioners but also new ways of delivering services, new roles and skills for existing practitioners, and probably new types of practitioners. The Act has been designed to be flexible so that it is possible to respond to workforce needs as they arise without the requirement to change the law whenever there is a need for new scopes of practice or ways of working.
- 3.8 Authorities that have developed new scopes of practice include the Nursing, Pharmacy and Medical Councils. It seems that such professional bodies have taken these initiatives mainly in response to needs they have perceived, in some instances following similar developments overseas.
- 3.9 District Health Boards and others have raised concerns that authorities sometimes choose to define scopes of practice too narrowly and by doing so limit rather than improve workforce flexibility. Concerns have also been voiced that authorities do not take full account of professional perspectives or experience when they develop scopes of practice.
- 3.10 The Nursing Council's development of the scopes of practice for enrolled nurse and nurse assistant has been the subject of considerable discussion in the nursing profession over a prolonged period. In 2007 Parliament's Regulations Review Committee reported on its consideration of a complaint by the New Zealand Nurses Organisation.<sup>[16]</sup> The committee found that the Notice of Scope of Practice that the Nursing Council issued in 2004 had an unauthorised retrospective effect on a group of nurses who began training or graduated between 2000 and September 2004. In response to this report the Government requested that the council change the scope of practice for the affected nurses but, after further consultation, the council declined to act. As a result, in September 2008 the Government successfully moved a motion in the House to use powers under the Regulations (Disallowance) Act 1989 to amend the scope of practice accordingly.

- 3.11 In the light of this controversial incident some in the nursing profession have called for a review of the policy that makes responsible authorities responsible for setting scopes of practice and for making other decisions that affect the profession. Some suggest that the Minister of Health should have the power to intervene or that the profession or others should have a stronger role.
- 3.12 It is important, however, to look closely at the findings of the Regulations Review Committee in this case. The committee recommended a change only because of the retrospective nature of the Notice. Although the committee found that the council's consultation process could have been improved, it also found that the council had complied with the Act's requirements and it did not agree to the broader remedies that the complainant had sought.
- 3.13 Given that Parliament designed the Act to limit the Minister's powers, allowing ministerial intervention in setting scopes of practice would be a significant change. Similarly, the Act deliberately limits the power of employers, professions and professional organisations by the way that authorities are structured, appointed and empowered and a change to how authorities decide on scopes would materially affect this balance. While this case raises some questions about consultation processes and whether authorities are seen to be complying with their responsibilities under the Act, it does not warrant altering a fundamental aspect of the design of the Act.
- 3.14 The Act requires that before specifying or amending a scope of practice, an authority must consult with its practitioners and other organisations that the authority considers will be affected by the proposal. Some practitioners and organisations are concerned that authorities are sometimes not consulting widely enough on such proposed changes. The review finds that these consultation processes could be improved and that it would be helpful if there were well-publicised ways for interested parties – particularly those responsible for delivering and developing services – to bring to the attention of authorities the need for new or amended scopes. In addition, authorities should review their scope(s) of practice at regular intervals to ensure that they are still relevant and during those reviews the authority should ask for comment from interested parties. Best practice approaches in developing scopes of practice are further discussed in paragraph 4.2.

**Recommendation 3:** That responsible authorities improve the processes around scopes of practice including developing a set of principles and guidelines, regular review, a central web-based point for notifying new consultations, and processes to allow any interested party to propose new or amended scopes.

- 3.15 Some commentators have expressed concerns that authorities are not sufficiently responsive to workforce or professional needs in matters other than scopes of practice. For example, District Health Boards think authorities have sometimes set unreasonably high requirements, as noted above (paragraph 3.9), or are unnecessarily risk-averse when accrediting overseas-trained practitioners.

- 3.16 The Act's principal purpose is to protect the health and safety of members of the public. If an authority's actions reduce access to health services then those actions may affect the health of members of the public. Authorities must balance the need to protect the public health by having a workforce to provide services against the need to protect safety by ensuring a certain level of competence.
- 3.17 While the Act gives authorities flexibility in respect of individual practitioners and their scopes of practice some authorities appear to focus largely on the safety aspect and therefore tend to be quite risk-averse. Other authorities have been more flexible by, for example, recognising a range of overseas qualifications. Authorities also vary in the flexibility they apply in using their power to add conditions on to a practitioner's registration. Such conditions can either broaden or constrain a practitioner's practice.

**Recommendation 4:** That responsible authorities consult on and take account of the health services impact of their decisions and carefully weigh these up against considerations of public safety and, where appropriate and safe, they consider using the power they have under section 21 of the Act to authorise scopes of practice for individual practitioners.

- 3.18 Another area of concern to District Health Boards and other employers is the increase of costs associated with the Act. For many professions the Act brought significant increases in registration and other fees. Such increases were partly a result of establishing new authorities but were also due to the costs associated with new programmes to demonstrate continued practitioner competence.
- 3.19 Authorities are required to publish fees in the parliamentary Gazette. These fee notices are regulations that Parliament's Regulations Review Committee can examine and they could be disallowed or amended under the Regulations (Disallowance) Act 1989. The committee in 2007 reported on its examination of the fees set by the Midwifery Council<sup>[17]</sup> and has also made some inquiries into fees set by other responsible authorities. Authorities should take account of the committee's report, should be very open in explaining how they set fees and, where possible, should explore options for saving and sharing costs.

**Recommendation 5:** That responsible authorities, mindful of the impact of practitioner fees on the health care system, try to restrain cost growth, look for ways to make efficiencies, minimise fee increases, and openly explain the basis for their fees and any increases.

## **Communication and engagement with practitioners and professional groups**

- 3.20 The Act is based on a system in which responsible authorities, which are governed by an appointed board with a majority of health practitioner members, make decisions about professions. To function effectively authorities must maintain the confidence and respect of the professions for which they are responsible.
- 3.21 This review finds that most but not all responsible authorities have the confidence of their professions. Authorities' decisions have from time to time been the subject of significant criticism from members of their professions. Some level of criticism is to be expected, however, because the interests of professions will not always align with the authority's focus which must be on protecting the health and safety of members of the public.
- 3.22 From time to time a particular authority seems to be very frequently at odds with significant parts of the profession(s) for which it is responsible. Such ongoing tensions make it difficult for the authority to adequately fulfil its functions.
- 3.23 Some professional organisations have made submissions to this review that ongoing disagreements of this sort arise because the membership of the authority is out of touch with the profession(s) or with parts of the profession(s). These organisations argue that elections should be a part of the appointment process because they would help ensure that the members could better represent the professional perspective. This issue is further considered in the discussion of the Ministry of Health's role in appointments to the authorities (see paragraphs 5.16 to 5.41).
- 3.24 It must be understood that the authorities as regulators do not represent the professions for which they are responsible – that is the role of the professional associations. Nevertheless, it is important that all authorities establish and maintain respect and confidence from the profession(s) for which they are responsible. To do so, an authority and members of its profession(s) need to communicate well and frequently with each other. Most authorities publish regular newsletters and most hold workshops and meetings for practitioners – usually taking these to regional centres.
- 3.25 The Act requires authorities to consult with practitioners or their representatives before they issue a notice to define, remove or change a scope of practice or the associated qualifications. Authorities generally take this responsibility seriously and consult carefully. There are cases where, despite consultation, groups are dissatisfied because their point of view was not followed. These outcomes are inevitable but their potential impact means that authorities need to take particular care to explain their final decisions.

- 3.26 Authorities have to decide on a number of other key matters that affect the professions for which they are responsible. These matters include establishing processes for competence and recertification programmes, and setting standards of clinical competence, cultural competence and ethical conduct. In all of these matters it is good practice for authorities to work closely with practitioners and their representatives so that decisions are seen to be fair and workable.
- 3.27 Engagement between authorities and their professions is not a one-way process. As noted above, authorities should establish ways to gather input from professions and from individual practitioners. Equally, though, practitioners and particular professional organisations have a responsibility to take the initiative in communicating with their responsible authorities.
- 3.28 Authorities' success in engaging and communicating with their professions should be a measure of their performance. Developing agreed standards and performance measures should be part of the role of the Ministry of Health and should feed in to the proposed further review of the Act. This area for improvement is addressed further under the role of the Ministry of Health below (from paragraph 5.53).

## Chapter 4: Collaboration among Responsible Authorities

- 4.1 Responsible authorities vary considerably in the size and complexity of the professions for which they are responsible, as well as in their resources and experience. It would be surprising if they did not also vary in their capabilities and performance. This chapter looks at the different functions that authorities have and finds that significant gains could be made if authorities worked more closely together to define and follow best practice.

### Prescribing scopes of practice and qualifications

- 4.2 Scopes of practice defined by responsible authorities rather than specified in legislation were a significant and controversial new concept in the Health Practitioners Competence Assurance Act 2003. The intention behind this aspect of the Act was to support workforce flexibility so that health professionals match with new service models and new technologies.
- 4.3 To work as intended, scopes of practice should be open to regular review as proposed in 0. The way that scopes are defined, however, should also be the subject of review. In particular, principles are needed to guide authorities when they are developing or reviewing scopes. These principles might cover issues such as:
- defining scopes only as needed to protect public health and safety rather than responding to professional preferences
  - defining broad rather than narrow scopes to enable as much workforce flexibility as is compatible with protecting public safety
  - setting qualifications that are the minimum requirements for public safety
  - allowing for movement between scopes by, for example, recognising the relevance of prior learning
  - consulting widely and openly without predetermined positions, and carefully evaluating and responding to submissions
  - basing decisions on the best available evidence including from other professions especially where scopes of practice overlap.

### Accrediting and monitoring educational institutions and programmes

- 4.4 All responsible authorities accredit New Zealand educational institutions and courses. The chiropractic, medical and pharmacy authorities do it in conjunction with Australian counterparts. Accreditation is a specialist task with processes that are similar regardless of the course or programme being accredited.

- 4.5 The changes to Australian health professional regulation that are currently being developed for introduction in 2009<sup>[18]</sup> include new national arrangements for accreditation. Initially accreditation functions will be assigned to existing agencies but they will, within 12 months, be required to meet national standards. Within three years the arrangements will be reviewed in order to decide whether the functions will continue with the external agency or will be managed by a single process.
- 4.6 Given the commonalities between processes, as well as the need to ensure best practice across all professions and the existing links with Australia, the long-term plan should be to work towards a joint accreditation scheme with Australia covering all regulated professions. There are, however, differences between New Zealand and Australia – not least being that only nine professions will initially be registered across all Australian states. Thus it may take some time to achieve any trans-Tasman scheme. In the meantime, collaboration among authorities within New Zealand should improve both processes and efficiencies.

**Recommendation 6:** That responsible authorities work together and with Australian counterparts to identify and share best practice principles and arrangements for accreditation of educational institutions and programmes and that the Ministry of Health gives further policy consideration to developing a Trans-Tasman joint accreditation system for regulated professions.

### **Practitioner registration particularly for overseas-trained practitioners, issuing annual practising certificates and maintaining registers**

- 4.7 Responsible authorities must determine policies for registering individuals and issuing annual practising certificates. In relation to New Zealand-educated practitioners, undertaking this function is generally straightforward because the authority also accredits educational institutions and courses. The more challenging part is setting standards for and assessing applications from overseas-trained practitioners.
- 4.8 The Act requires that applicants for registration must be able to communicate effectively and must satisfy the authority that they are able to communicate in and comprehend English sufficiently to protect the health and safety of the public. They must also be fit to practise: that is, they must have no recent imprisonable convictions, be physically and mentally able to practise, not be subject to disciplinary proceedings or investigations, or otherwise be someone that the authority has reason to believe might endanger public health or safety.
- 4.9 District Health Boards, other employers and some overseas-trained practitioners have voiced concerns that standards are inconsistent and appear sometimes to be an unnecessary barrier to the entry of competent practitioners. Some suggest that authorities are acting to protect the market position for existing practitioners by making entry difficult.

- 4.10 On the other hand, concerns have been voiced in the media and elsewhere in recent years that the quality of some overseas practitioners is dangerously low and that the number of complaints or prosecutions against such practitioners is higher than expected.<sup>1</sup> In some high profile cases, practitioners have been registered as a result of false documentation.
- 4.11 With the exception of medical practitioners, health practitioners who are already registered in Australia can automatically be registered in New Zealand. This registration is allowed because section 158 of the Health Practitioners Competence Assurance Act 2003 provides that the Trans-Tasman Mutual Recognition Act 1997 prevails over the 2003 Act. Medical practitioners are explicitly excluded from the trans-Tasman agreement.
- 4.12 Authorities take a variety of approaches to verifying identity, ensuring fitness to practise and assessing the experience and qualifications of overseas-trained applicants (see Appendix 5). All require verified proof of identity and documentation. Some require a certificate of good standing from a registration authority; others ask for character references or a police report; many ask for self-declarations; and some have individuals assessed by the professional board or a board committee. Some require all applicants to sit an examination; others recognise certain qualifications as equivalent to New Zealand qualifications or accept people who are registered with a comparable authority; and others review all individuals' qualifications.
- 4.13 In this area, authorities could learn much from each other and from approaches in other jurisdictions. An agreed standard about how to assess and apply the Act's 'fitness to practise' requirements would be helpful for authorities, for applicants and for potential employers. Such a standard should make reference to similar work that is progressing in Australia. Its approach should try to match the processes to the risks, and strike the appropriate balance between protecting safety and not damaging health by posing an excessively high barrier to health service delivery.

**Recommendation 7:** That responsible authorities should collaborate with the Ministry of Health and Australian authorities to develop risk-based standards, processes and assessment models to be used for assessing overseas-trained practitioners.

- 4.14 A particular question has been asked about the way that responsible authorities designate the qualifications for scopes of practice. Section 12(1) of the Act requires authorities to prescribe the qualifications by notice in the parliamentary Gazette. Section 12(2)(a) states that, in prescribing qualifications, an authority may designate 'a degree or diploma of a stated kind from an educational authority, whether in New Zealand or abroad'. In addition section 15(2) allows an authority to treat any overseas qualification as equivalent to a prescribed qualification.

<sup>1</sup> In a 2007 analysis the Health and Disability Commissioner found no significant difference between the number of complaints received about doctors trained in New Zealand and those trained overseas. Some differences became apparent when comparing doctors trained in different regions.

- 4.15 When prescribing qualifications by notice in the Gazette under section 12(1), most authorities name one or more specific qualifications from named educational institutes that they have accredited. Some notices, however, are less specific; for example, they state “an undergraduate degree approved by the Board”. Since the Gazette notices are, according to section 14(4) a regulation for the purposes of the Regulations (Disallowance) Act 1989, it is important that they stand alone and fully describe the prescribed qualifications. Such clarity will also be helpful to prospective applicants. Some authorities also specify in their notices various overseas qualifications that they recognise. This practice is also very helpful to intended applicants. It has, however, proven impractical to maintain such lists as fully current because overseas qualifications change from time to time without notice being given to the authority.
- 4.16 The review finds that authorities should be careful to fully prescribe qualifications by notice in the Gazette and, so far as is practical, should also make available on the Internet and in their offices a list of the overseas qualifications that the authority recognises as equivalent to the prescribed qualifications. This should be a matter that is considered by responsible authorities when they are looking to improve their processes around scopes of practice under Recommendation 3.
- 4.17 Registrars of the responsible authorities may decline to issue an annual practising certificate if they have reasonable grounds to believe that the applicant has not maintained competence, has not met various requirements or conditions, is unable to practise, or has not practised in the previous three years. Authorities must maintain and publish registers and make them available for inspection.
- 4.18 The requirements for assessing maintenance of competence are covered from paragraph 4.21 below. Other processes for issuing annual practising certificates and maintaining registers are common to all authorities. It may be possible for authorities to share some administrative aspects of these processes and some authorities have already moved to do so. It is noted that the Occupational Therapy Board is the first authority to set up online processes for registration and issuing of annual practising certificates and that other authorities are looking to develop similar processes. Most authorities make their registers available for searching on the Web but, as mentioned, in paragraph 3.3 above, few make use of their power to include address information. The new Australian system will have a single national agency that will be responsible for registering practitioners and maintaining registers.

## **Reviewing and promoting competence**

- 4.19 Under section 36 of the Act authorities may review a health practitioner’s competence after receiving a complaint or at any other time. After such reviews authorities may make orders that the practitioner undertake a competence programme, have a restriction on practice, or sit an examination or assessment.

4.20 Most authorities have developed similar processes for reviewing practitioner competence involving onsite review of the practitioner's performance. There is potential to make gains from authorities jointly generating a set of agreed principles and processes for reviews that can be used as a set of guidelines for all authorities and their practitioners. Sue Ineson's report for this review<sup>[6]</sup> gives such a list on page 58 and would be a useful starting point.

### **Recertification programmes to ensure ongoing competence**

4.21 As mentioned above, authorities may decide not to issue an annual practising certificate if they have reasonable grounds to think the applicant has failed to maintain the required standard of competence. Most authorities have developed their own approach to assessing whether an applicant has met this criterion by setting up recertification programmes under section 41 of the Act.

4.22 As Ineson<sup>[6]</sup> discusses, there is no internationally agreed best way to assess health practitioner competence. New Zealand authorities' approaches include:

- a simple declaration from the applicant that they have maintained their competence
- an online self-assessment against competencies
- evidence of attending a set number of hours of approved professional development activities
- peer review
- other quality assurance activities
- review of evidence of practice against a set of criteria
- recognising employer-based processes such as credentialing or appraisal.

4.23 Recertification processes are valuable though it must be acknowledged that they can never be foolproof. Indeed, if there is an excessive focus on uncovering bad practice, a process may become punitive and lead to avoidance behaviour rather than being supportive of learning. Authorities should be aware that such programmes can add significant costs to the system and should work to match costs to risks and gains. Some authorities have annual recertification programmes while others work on cycles of three years or longer. This is an area where authorities can learn from each other to develop the best and most cost-effective approach for their practitioners.

### **Managing practitioners who may be unable to function for practice**

4.24 Under section 45 of the Act those in charge of health provider organisations, employers, health practitioners and medical officers of health must notify the Registrar for the relevant responsible authority in writing if they believe that a health practitioner is unable to perform the functions needed to practise.

- 4.25 Responsible authorities must have processes to investigate and respond to such concerns and the Act gives them various powers to follow these processes. Some authorities have had no or few complaints notified; others have had a steady stream to deal with. Most authorities include in their annual reports statistics about practitioners who are unable to function because of ill health.
- 4.26 As with some of their other functions, responsible authorities have approached this issue in a variety of ways. The websites of some authorities carry clear instructions about health practitioners' responsibilities to make concerns known, how to raise concerns and what process the authority will follow in response. The websites of others are silent on the matter. Most authorities have policies to deal with health problems but some may not yet have developed or tested these policies.

### **Setting standards for clinical and cultural competence and ethical conduct**

- 4.27 Responsible authorities are expected to set standards of clinical competence, cultural competence and ethical conduct for their profession(s). Most have done so although some are still developing standards appropriate for their practitioners.
- 4.28 Some standards for clinical competence are likely to be specific to the particular profession. Some, however, may be generic to all or several health professions. There is potential to make gains from authorities collaborating on the development of the latter group of standards. It is likely that even more of the standards in the cultural and ethical areas will be common across professions and could be improved by a collaborative approach.
- 4.29 Some submissions to this review claim that standards, particularly ethical standards, are matters for a profession rather than the responsible authority to set. Others point out that responsible authorities could properly refer to professional organisations and best evidence in developing standards of clinical competence. Cultural and ethical standards, on the other hand, are matters on which others besides the profession can and should be expert. The Health Select Committee considered these points when the Bill was before the House of Representatives, and there is no reason to change the wording that was agreed at that time.
- 4.30 The review finds, however, that there is significant common ground among professions on all standards and much could be gained by acting collaboratively to compare and review across authorities and with other stakeholders. Given that nearly all authorities have already published standards, collaborative working will be most useful when they are next reviewing those standards.

## **Liaising with other responsible authorities**

- 4.31 Given that authorities all have to undertake the same functions, they can learn from each other, share expertise and perform functions together. They are sharing and working together in these ways to varying degrees already and are planning to increase collaboration in future. This sort of collaboration helps address Cabinet's concern about the possible 'proliferation' of responsible authorities.
- 4.32 Some boards share costs and resources already. In 2006 the Medical Laboratory Science Board joined with the Medical Radiation Technologists Board to form a joint company, the Medical Sciences Secretariat, which now provides services to both boards. In 2008 five smaller authorities<sup>2</sup> moved into shared premises and established a not-for-profit arrangement for sharing a number of staff and infrastructure costs. The newly established Psychotherapists Board is sharing office space and some secretarial services with the Occupational Therapy Board.
- 4.33 Authorities could share more of their administrative capabilities and functions rather than developing all of their own systems. At present, for example, there are about 10 different IT systems with different database structures, and a similar number of website designs. Similarly, most authorities pay for all their own legal and communications advice and, apart from those mentioned in paragraph 4.32 above, most rent their own separate premises.
- 4.34 Sharing is not necessarily easy, especially when authorities have already developed as far as they have by themselves. For example, because changing IT systems is very expensive, it would take many years before any savings from sharing offset these costs. Nevertheless, when authorities are considering upgrades or changes to systems, processes or policies, they should take the opportunity to look at whether they could adopt or adapt existing models from other authorities. 'Not re-inventing the wheel' is only a truism because it makes a lot of sense.
- 4.35 In 2004 the authorities established Health Regulatory Authorities of New Zealand (HRANZ) and in 2008 all of them signed a memorandum of understanding to support that association and fund a small secretariat. Under the auspices of HRANZ there have been regular meetings both at governance (chairs) and operational (chief executives and registrars) levels, and authorities have completed a number of shared projects.
- 4.36 HRANZ has considerable potential for much greater collaboration on issues of mutual interests. It is also a good vehicle for communication between authorities and stakeholders.

<sup>2</sup> Chiropractic Board, Dietitians Board, Optometrists and Dispensing Opticians Board, Osteopathic Council, Podiatrists Board.

**Recommendation 8:** That responsible authorities actively explore ways in which they can share with and learn from other authorities in order to improve quality and, where possible, reduce costs.

DRAFT

## Chapter 5: The Ministry of Health's Role

- 5.1 The Ministry of Health is the government department that administers the Health Practitioners Competence Assurance Act 2003. This chapter looks at the Ministry's roles and makes recommendations for some extensions designed to help achieve the Act's purposes in full.
- 5.2 The Ministry's responsibilities are to:
- investigate and enforce possible breaches of parts of the Act that are not dealt with by responsible authorities or the Health Practitioners Disciplinary Tribunal
  - administer the processes for ministerial appointments to and removals from responsible authorities and the Health Practitioners Disciplinary Tribunal
  - administer the list of restricted activities under section 9 of the Act
  - administer the processes for designating new health services as registered health professions (this area of responsibility is considered in Chapter 6: )
  - administer processes associated with the Minister of Health's powers (sections 123 to 129 of the Act) including the provision of statistical information
  - carry out this review of the Act as required under section 171.
- 5.3 In addition the Ministry is responsible for advising the Minister, Government and Parliament on the operation of the Act. This advice deals with, for example, responsible authorities' annual reports, fee notices, and notices of scopes of practice and associated qualifications when these are tabled in Parliament.
- 5.4 This chapter identifies areas where the Ministry should play a more active role in administering and overseeing the Act and in reporting on how well the Act is operating to protect the health and safety of the public.

### Enforcement of the Act

- 5.5 Sections 7, 9, 33, 44, 59, 78, 95, 98 and 172 of the main Act and paragraphs 12 and 13 of Schedule 1 set up offences that are punishable on summary conviction. The Ministry of Health investigates and can bring about prosecutions for offences under these sections.
- 5.6 To date complaints, investigations and prosecutions have only involved sections 7, 9 and, on one occasion only, 172. Section 7 makes it an offence for unqualified people to claim to be registered health practitioners. Section 9 states that certain activities are restricted to particular health practitioners.

## **Section 7: Unregistered people must not claim to be registered**

- 5.7 Section 7 makes it an offence for an unregistered person to claim to be a registered health practitioner. The first part of the section states that a person may use names, titles, abbreviations or the like that state or imply that they are registered as a practitioner of a certain kind only if they are in fact such a practitioner. The second part states that an unregistered person may not claim to be practising a profession as a practitioner of a particular kind and may not do anything that is calculated to suggest that they are practising or willing to practise as such a practitioner. The third part also prohibits any other person from making false claims on behalf of an unregistered person. Offences are punishable on summary conviction by a fine of up to \$10,000.
- 5.8 Submissions to this review and comments at workshops indicate that some do not understand the provisions of section 7 fully. As described in paragraphs 1.24 and 3.2, the Act stops unqualified people from claiming to be registered practitioners but it does not stop them offering services (apart from a limited range of restricted activities). Some practitioners thought this system was wrong because it did not protect the public from potentially dangerous services offered by unqualified people. The Act, however, is clearly designed to allow the public to choose for themselves between a registered practitioner and, at their own risk, an unregistered person. Only where activities carry a higher risk of harm is the activity restricted to registered practitioners.
- 5.9 These provisions only work if the public understand the difference between a registered and an unregistered person. Paragraph 3.4 has proposed a more substantial role for responsible authorities in promoting public awareness and 0 proposed that the authorities and the Ministry of Health are more active in informing the public about how the Act works. In addition, the Ministry's role in enforcing the provisions against unregistered people claiming to be registered opens up useful opportunities to further educate the public.
- 5.10 Some other jurisdictions have a list of titles that only registered health practitioners can use. Such an approach makes enforcement more straightforward and may help the public to better understand the system. However, the New Zealand Act arguably provides more flexibility and prevents situations where, in an effort to imply that they are registered, unregistered people use titles that are very close but not identical to protected titles. After Australia introduces a list of protected titles, New Zealand will be able to learn from its experience and might revisit this question in the next review.
- 5.11 Responsible authorities and professional bodies are concerned that the Ministry of Health has not brought more prosecutions for offences under section 7 or section 9 (restricted activities) of the Act.

- 5.12 In considering if a prosecution should be commenced, the Ministry adheres to the Solicitor-General's *Prosecution Guidelines* published by Crown Law.<sup>[19]</sup> In the first instance a complaint about a possible breach of section 7 is investigated to see if there is evidence that the complaint is a more serious one such as a refusal to adhere to a letter of warning, or concern about a significant risk of public harm. If there is no evidence of a more serious nature then the approach is generally to inform the person of the law and give them a chance to correct any false use of titles or any advertisements that may be misleading.
- 5.13 Evidence of a more serious complaint is likely to result in prosecution. Successful prosecutions send a clear message about the seriousness of offending and help inform the public. In accordance with the guidelines the Ministry will avoid commencing prosecutions that are unlikely to succeed.

### **Section 9: Complaints about unregistered people practising restricted activities**

- 5.14 Complaints about possible breaches of section 9 (certain activities restricted to particular health practitioners) are, by their nature, more serious. These activities are ones where, by definition, the public is at risk of serious or permanent harm. Offences are punishable on summary conviction by a fine of up to \$30,000.
- 5.15 In case of complaints under section 9 the Ministry of Health investigates the complaint and, if it finds there is evidence to substantiate the complaint, then it seriously considers prosecution. Sometimes it can face difficulties in bringing a prosecution because of the difficulty in getting sufficient evidence to prove the case and gain a conviction. Unambiguous wording of the restricted activity is also important to successful prosecutions – this area is discussed further in paragraphs 5.42 to 5.52 on restricted activities.

### **Appointments to responsible authorities**

- 5.16 This section deals with the processes of appointing members to responsible authorities. It covers a number of issues: the size of authorities, the definitions of lay and professional members and the proportions of each, the processes for calling for nominations and making appointments, and the provisions for elections for some members. The issues to do with appointing members to the panel for the Health Practitioners Disciplinary Tribunal are dealt with in Chapter 7.

### **The size and make-up of authorities**

- 5.17 Under section 120 the Minister of Health appoints between five and 14 members to responsible authorities. So far no boards have had fewer than six members. Suggestions have been made, however, that five-member boards may be appropriate to keep the governance costs down, especially for professions with a smaller number of members. If an authority had fewer than five members, it would find it difficult to always have a quorum and still have at least one lay member.
- 5.18 As happened when the Health Select Committee was considering the Bill, some submissions call for a requirement that Māori be represented on each authority.

A specific legislative requirement was considered unnecessary at the time the Act became law, but the process of making appointments has always ensured that each authority has had at least one member with Māori affiliations. This representation is in line with the Cabinet Office advice about ensuring diversity in board membership and in particular considering ethnic mix.<sup>[20]</sup> The review finds no reason to recommend a change at this time.

- 5.19 Membership must include two laypeople if the board has eight or fewer members and three laypeople if it has nine or more. Having at least two or three laypeople on each authority was considered carefully at the time that the Bill was being designed and debated. Laypeople were included in the Medical Council under the Medical Practitioners Act 1995 but were not a required part of other authority membership before the Health Practitioners Competence Assurance Act 2003 came into force. In general, lay members are thought to have helped authorities function more effectively. Recently the Medical Council have proposed to the Minister of Health that the council should be made up of 12 members, of whom four would be laypeople.
- 5.20 Some submissions state that people who have at an earlier time been health practitioners should not qualify as lay members. The definition of layperson in the Act is a person who is neither registered nor qualified to be registered as a health practitioner. This provision seems to be sufficiently clear.
- 5.21 In addition, some submissions call for an amendment to the definition of layperson so that it includes a specific reference to being a consumer. The Health Select Committee considered this same point in 2003 but it felt that specific reference to consumers was not needed. The Ministry of Health refers to the *Guidelines for Consumer Representation*<sup>[21]</sup> and the Cabinet Office circular on government appointments.<sup>[20]</sup>
- 5.22 Other submissions claim that the definition of layperson is too wide because it could include people who were employed by or had an interest in the health sector and these people might be partisan or have conflicts of interest. Cabinet<sup>[22]</sup> has agreed that as a general rule Ministers should not appoint public servants to statutory boards but that this rule does not extend to employees of the wider state sector such as District Health Boards. All members of an authority have a collective responsibility to protect the public regardless of their other affiliations. The review finds no general reason to disbar someone because they have a particular knowledge of or interest in the health sector. The rules for managing conflict of interest in Schedule 3 to the Act are important in such situations and will apply to professional members as well. On occasion, as the State Services Commission guidelines note,<sup>[23]</sup> the extent of potential conflicts of interest could be such that they would be a matter to consider at the time of appointment.
- 5.23 Some submissions claimed that it was inappropriate for lawyers or barristers to be appointed as laypersons especially for appointments to the Health Practitioners Disciplinary Tribunal. Submissions on this point were, however, mixed and the Review does not find it necessary to rule that lawyers or barristers cannot be laypersons.

- 5.24 Under the Act the majority of the members of an authority must be health practitioners. Some submissions support changing this provision to specify that the health practitioners are members of the profession(s) regulated by that authority. When the Health Select Committee recommended the addition of the provision requiring a majority of health practitioners as members, it stated ‘authorities will need sufficient members with clinical knowledge to adequately carry out their functions’.<sup>[11]</sup> This provision will generally mean that practitioners from the profession(s) in question are needed, and they have nearly always made up the majority under ministerial appointments. Occasionally, however, practitioner members from a related profession have been appointed. They have brought valuable expertise to the authority and their inclusion appears to have worked satisfactorily. Currently only one such member remains<sup>3</sup> but the review can see no reason to require a legislative change to prevent such exceptions.
- 5.25 A few submissions have voiced concerns that, where authorities regulate more than one profession, the membership of the authority may not be constituted appropriately to make good decisions for all its professions. Currently only two authorities regulate more than one profession<sup>4</sup> but in future regulation of multiple professions could become more common if new and sometimes small professions become regulated. Any legislative requirement, however, for proportional representation of particular practitioners on an authority could lead to large authorities and reduce flexibility in the long run. It would also not necessarily address the concerns of practitioners who are still in a minority. The review recognises the concerns about some decisions of some authorities but finds that changing the rules about the mix of members is not the best way to resolve such concerns. The key requirement is that all authority members are collectively able to carry responsibility for undertaking the task of governing the authority in order that it properly fulfils its functions.

### **Appointment procedures**

- 5.26 Section 120(3) requires the Minister of Health to invite organisations and individuals to make nominations and to consider all nominations before making appointments. Section 87 of the Act also requires the Minister to maintain a panel of lay and practitioner members for the Health Practitioners Disciplinary Tribunal (see Chapter 7). The Ministry of Health manages these processes, making reference to guidance provided by Cabinet<sup>[20]</sup> and the State Services Commission.<sup>[23]</sup> It places calls for nominations in public newspapers and sends them to a range of key stakeholder organisations, giving four weeks to submit nominations. Once it receives nominations, the Ministry checks that the individuals are eligible to be appointed to the position. To assist the Minister in making a selection, it sends the list of nominations to the current chair of the authority for comment. Usually chairs try to analyse skill gaps on the authority and make recommendations about how well individual nominees might fill these gaps. The Ministry forwards the full list of eligible nominees, along with

<sup>3</sup> The Medical Laboratory Science Board includes a medically qualified professor of pathology.

<sup>4</sup> The Dental Council regulates dentistry, dental hygiene, clinical dental technology, dental technology and dental therapy; and the Optometrist and Dispensing Opticians Board regulates optometry and optical dispensing.

comments and recommendations, to the Minister. Cabinet must approve the Minister's proposed appointments before they are finalised and published in the Parliamentary Gazette.

- 5.27 These appointment processes are relatively ad hoc and opaque. Various submissions call for improvements. In the United Kingdom some authorities have developed specific guidance about skills looked for in members of the authority.<sup>[24]</sup> The recent United Kingdom White Paper about health professional regulatory reform<sup>[25]</sup> notes that in future 'all members of all councils will be appointed independently ... against clearly specified criteria and competencies'. Criteria of this sort would be very useful in New Zealand, and experience elsewhere should be used in the development of a local set.

**Recommendation 9:** That the Ministry of Health consults with responsible authorities and any other interested stakeholders about the processes for appointing members to responsible authorities and to the Health Practitioners Disciplinary Tribunal panel, and develops a set of criteria and competencies to help ensure the best appointments are made.

### **Elections to responsible authorities**

- 5.28 Under previous legislation three out of the 11 professional regulatory authorities had some members elected by their respective professions.<sup>5</sup> As the Health Select Committee report noted, the Health Practitioners Competence Assurance Act 2003 'aimed for all professions to have their members appointed in the same way, by ministerial authority, to reinforce the principle that registration authorities are there to protect the public'.<sup>[11]</sup>
- 5.29 The Act, however, includes in section 120(4) the power to make regulations that provide that one or more of the health practitioner members must be practitioners who have been elected in an election conducted by the authority. This power was a part of the original Bill as presented to the House of Representatives in 2002. It represents something of a compromise between the desire to have a consistent process with ministerial appointments for all authorities and the recognition that some professions were strongly of the view that elections should at least play a part in selecting the members of their responsible authority.
- 5.30 The Act does not, however, give any indication when it is intended that the power to make regulations under section 120(4) should be used. Regulations would be made by Order in Council and Cabinet would need to agree to them. Recently Cabinet considered a request from the Minister of Health that regulations should be made in respect of the Medical Council, and Cabinet asked that the matter should be considered as part of this review.
- 5.31 Since the Act came into force there have been appointments to boards on many occasions. These appointments have been made following the processes outlined in paragraph 5.26. The Medical Council, however, has on two occasions

<sup>5</sup> Dentistry, medicine and pharmacy.

held elections at the time of the call for nominations and has referred the results of the elections to the Minister of Health to represent its nominations. On the first occasion the council took this approach, the then Minister appointed the top-polling candidates in the elections to the vacant positions. On the second occasion in 2006 the Minister appointed the three highest-polling candidates but filled the fourth vacancy with the seventh-highest polling candidate (who was a sitting member of the council).

5.32 Under the Medical Practitioners Act 1995, the profession and the Medical Council elected four members of the Medical Council. A wide range of medical professional bodies have continued to press the Government to reinstate elections as at least a part of the appointment process. They did so at the time the Bill was being designed and considered in the House and renewed these calls in 2006 when, as described in paragraph 5.31, the then Minister failed to appoint all of the top-polling candidates.

5.33 In 2006 the then Minister of Health asked the Ministry of Health to consult on whether regulations should be made for elections in respect of the Medical Council. The Ministry issued a discussion document in April 2007 to which it received 15 responses. The nine submissions in favour of elections came from the Medical Council, the New Zealand Dental Association and seven medical organisations representing a wide range of medical practitioner opinion. The five submissions against the proposal came from the Nursing, Dental and Pharmacy Councils, the Health and Disability Commissioner and the Federation of Women's Health Councils.

5.34 The survey document issued in the first stage of this review included this specific question:

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

5.35 Of the 114 responses to the survey, 43 specifically commented on the issue of elections. Fifteen respondents thought that the system of appointments rather than elections should continue with some improvements. Among the respondents with this view were six responsible authorities (including the Pharmacy and Dental Councils, both of whom had previously had elections) and four professional organisations (none medical). The Health and Disability Commissioner did not support elections.

5.36 The main arguments against elections may be summarised as follows.

- There may be a perception that elected members sometimes put the interest of their professions before the interest of the public.
- Elected members are likely to be seen or to see themselves as representatives. Therefore they may have less independence and be in conflict with the authority's governance and regulatory roles.
- The Government can hold authorities to account for public safety if it appoints the members.

- Elections are not the best way to ensure that members have the right skills, qualities and experience. (For example, experience shows that women, Māori and some branches of professions tend to be less likely to be elected.)
  - The costs of elections could be substantial and would ultimately be a cost to the health system and the public.
  - Experience shows that elected members (of the Pharmacy Council) sometimes felt they had to represent the views of electors to the detriment of good governance.
  - There are international trends away from electing members, for example, in the United Kingdom and Australia.
  - Elections are not the only or best way to gain independence from government interference. An alternative would be to have an independent appointment body appointed by and responsible to Parliament (as proposed in the Health and Disability Commissioner's submission).
- 5.37 Of the remaining respondents who commented on elections in the survey, 28 favoured elections for some or all members. The Medical Council was the only responsible authority to state a preference for elections (six were against elections, seven did not comment on elections and two authorities did not make a submission). In addition to eight medical organisations, responses in favour of elections came from organisations representing some nine other health professions as well as some health unions and one consumer organisation.
- 5.38 The main arguments in favour of elections may be summarised as follows.
- Elections help to build and maintain professional confidence and trust in the authority, which is essential for its functioning.
  - Public confidence will also be enhanced if the public know that members have the confidence of the profession.
  - It is inequitable to have no representative voice on a body when there is a requirement to fund it: 'no taxation without representation'.
  - Practitioner elections help to protect the public against unsafe political interference. In particular, they help authorities to withstand pressure to lower standards to unsafe levels as a means of maintaining workforce levels – for example, to lower standards to allow the entry of overseas recruits.
  - Experience shows that a partially elected Medical Council has served the public well for many years.
  - There is no reason to suppose that elected members would be any less impartial than appointed members.
  - The proposed proportion of elected members (one-third) would still be a minority on the council and so would not be in a position to 'capture' the council.
  - Online election processes could be used to reduce costs of elections.

- Given that Parliament has included a power to regulate for elections and given that the medical profession and the Medical Council at least are united in their call for elections, it is reasonable to use the power to regulate for elections.

5.39 The arguments are largely the same arguments that were voiced at the time that the Bill was consulted on, designed and passed through Parliament. It was on the strength of these suggestions that Parliament included section 120(4) in the Act. This review finds that there is no reason to recommend removing or amending section 120(4). Nor does it find that regulations should be passed or the Act amended in favour of elections for all authorities.

5.40 The question of whether to allow elections should continue to be considered on a case-by-case basis. If it is accepted and acted upon so that the provisions for appointment processes are improved, it may be that the calls for elections will lessen.

5.41 The review also notes that professional organisations or responsible authorities in other professions could choose to hold elections to arrive at nominations – in the same way that the Medical Council has chosen to do since 2003.

**Recommendation 10:** That section 120(4) of the Health Practitioners Competence Assurance Act 2003, which gives the power to have some members of responsible authorities elected, should remain unchanged and the question of whether to allow elections should continue to be considered on a case-by-case basis.

## Administering the list of restricted activities

5.42 The Minister of Health can, under section 9 of the Act, restrict certain activities to registered health practitioners when, after consultation, the Minister is satisfied that there is a risk of serious or permanent harm from the activity.

5.43 The current list of restricted activities was consulted on and agreed in 2005. The activities are:

- surgical or operative procedures below the gingival margin or the surface of the skin, mucous membranes or teeth
- clinical procedures involved in the insertion and maintenance of fixed and removable orthodontic or oral and maxillofacial prosthetic appliances
- prescribing of enteral or parenteral nutrition where the feed is administered through a tube into the gut or central venous catheter
- prescribing of an ophthalmic appliance, optical appliance or ophthalmic medical device intended for remedial or cosmetic purposes or for the correction of a defect of sight
- performing a psychosocial intervention with an expectation of treating a serious mental illness without the approval of a registered health practitioner
- applying high velocity, low amplitude manipulative techniques to cervical spinal joints.

- 5.44 As discussed in **Error! Reference source not found.**, the restricted activity provisions mean that the Act takes a mixed approach: it is largely based on certification of title but includes an element of licensing for a limited number of risky activities. A number of other countries and jurisdictions use a similar mixed approach although the actual activities that they restrict vary. For example, the new Australian legislation will only restrict dentistry and optometry procedures and possibly elements of spinal manipulation.<sup>[18]</sup> Canadian provincial law by contrast lists many more activities. For example, in British Columbia<sup>[26]</sup> seven categories of 'reserved acts' are defined, including diagnosis; physically invasive and manipulative techniques; managing at births; applying or ordering hazardous energy (for example X-ray); prescribing medications; prescribing devices for vision, hearing or dental purposes; and ordering allergy or stress tests.
- 5.45 The list of restricted activities in New Zealand was developed after consultation as required under section 9(2). Under the approach taken, the purpose of the restricted activities provisions in section 9 was principally to ensure the continued restriction under the new Act of activities that carried risk of serious or permanent and that had previously been restricted to certain practitioners under the earlier profession-specific Acts.
- 5.46 A set of criteria was developed to help decide when an activity should be restricted (see Appendix 6). Six activities were proposed for restriction and were consulted on, amended and eventually adopted into regulation. After the regulation was made, the Ministry of Health consulted on and published a set of more detailed explanatory guidelines to complement the list of restricted activities.<sup>[27]</sup> These guidelines provide more information about how the Ministry would approach any complaints concerning possible breaches of section 9.
- 5.47 A number of submissions to the review stated that unregistered people should not be allowed to undertake any activities that are within the scope of practice of a registered health practitioner. However, such an approach would be a significant departure from the general design of the Act, which is based on certification of title rather than licensing to undertake tasks.
- 5.48 The review heard a number of concerns about the fifth activity listed in paragraph 5.43: 'performing a psychosocial intervention with an expectation of treating a serious mental illness without the approval of a registered health practitioner'. Concerns about this activity have been known for some time. They centre on two points. First, the definition is unenforceable because the meaning of both 'psychosocial intervention' and 'serious mental illness' is too vague. Second, it is unreasonably restricting social workers and counsellors, who can safely perform such activities even though not registered under the Act.
- 5.49 In April 2008 the Ministry of Health consulted on a proposal to remove or amend psychosocial intervention as a restricted activity. Following the consultation the Ministry has separately recommended to the Minister of Health that Cabinet approval be sought to revoke this restricted activity.
- 5.50 Submissions proposed adding a significant number of activities as new restricted activities. The proposed activities included fitting or supplying non-prescription contact lenses, tooth bleaching, providing care during childbirth, diagnosing

psychiatric disorders, practising medicine, practising anaesthesia, providing nutritional advice to unwell people, manipulating the spine, and using X-rays.

- 5.51 Most of the proposals above are not new. They were considered during the 2004 consultation. At that time it was considered for various reasons that these activities should not be added to the list of restricted activities. In some cases, other laws such as the Medicines Act 1981 and the Radiation Protection Act 1965 already control the activities satisfactorily. Other cases lack clearly established evidence that there is a need to restrict the activity to protect the public safety.
- 5.52 The review finds that the provision to designate restricted activities is appropriate and, with the exception of the psychosocial intervention activity, the current list of restricted activities is functioning as intended. The review finds no cause for any general increase in the number of restricted activities because a more wide-ranging list would move away from the basic design of the Act. It should be possible, however, to add to the list if new evidence is presented that an activity meets the published criteria for inclusion.

**Recommendation 11:** That the restricted activity concerning psychosocial interventions be revoked by Order in Council.

## **Oversight of the Act and the performance of responsible authorities**

- 5.53 If Recommendation 1 were accepted, the Ministry of Health would carry out a further review of the Act's operation and policy settings. That review would require the collection of better data to judge the effectiveness of the Act and the performance of responsible authorities. Evidence of effectiveness may be difficult to gather but workable options should certainly be considered. Gathering appropriate evidence of responsible authority performance is more straightforward. Already some authorities are considering such measures. In addition, the United Kingdom's Council for Health Care Regulatory Excellence has developed a system that could be adapted for New Zealand use.
- 5.54 As noted above, particularly in Chapter 3, some concerns have been voiced about the performance and decisions of some authorities. Sometimes these concerns arise through inadequate understanding of the roles and responsibilities of the authority; sometimes they relate more to poor communication between authority and stakeholders.
- 5.55 As the government department administering the Act and advisor to the Minister of Health, the Ministry of Health can play a number of useful roles. First, the Ministry can explain and educate about the Act and the functions of authorities. Second, the Ministry could arrange that, in consultation with authorities and sector stakeholders, a set of indicators of best practice is developed. These could then be used to measure authorities' effectiveness both as an ongoing exercise and in response to particular concerns. The Ministry may from time to time assist in mediating an agreement between an authority and sector

stakeholders.<sup>6</sup> Finally, the Ministry would have a role if a Minister of Health chose to use the power to audit an authority, which is provided in section 124 of the Act (that power has not yet been used).

- 5.56 One area where there is room for improvement is in ensuring that responsible authorities provide reports and information to Parliament as required under the Act. Authorities are required to provide an annual report and to publish fees and scopes of practice in the Parliamentary Gazette. Some authorities have not always fulfilled these requirements consistently and the Ministry has a role to ensure that they do so, as well as to advise the Minister of Health of any issues associated with any of the matters advised to Parliament.
- 5.57 An expanded role for the Ministry in overseeing the Act must recognise that responsible authorities have particular functions, powers and responsibilities and that the powers of government or government agencies are deliberately limited.

**Recommendation 12:** That the Ministry of Health arranges for a set of indicators to be developed in consultation with responsible authorities and other interested stakeholders to measure the effectiveness of the Health Practitioners Competence Assurance Act 2003 and to measure the performance of responsible authorities.

**Recommendation 13:** That the Ministry of Health consults with responsible authorities and other interested stakeholders to establish a standard template for authorities' annual reports and standard information to accompany notices of scopes of practice and fee changes.

## Statistical information

- 5.58 Section 123 of the Act gives the Minister of Health the power to require a responsible authority to supply him or her with any information, not including information about an identifiable individual, that it already holds relating to 'the discharge of the functions of the authority or of any of its committees, or to any matters connected with those functions'. This section was also part of the previous Medical Practitioners Act 1995.
- 5.59 Responsible authorities hold important information about the health practitioner workforce. All authorities hold information about the practitioners they register and about the issuing of annual practising certificates.
- 5.60 Authorities also collect more detailed survey information specifically about working patterns. This information typically covers type, place and hours of work as well as the ethnicity of the practitioner. The authorities either use these data to analyse and publish their own workforce reports<sup>[28-30]</sup> or make unidentifiable results available to the Ministry of Health, which analyses and publishes them.<sup>[31]</sup>
- 5.61 Governments, providers and professional organisations have increasingly accepted that workforce planning is essential to the future health system and that

<sup>6</sup> It has already provided this form of assistance in a long-running dispute involving the Chiropractic Board and others.

comprehensive, accurate and timely workforce data are a key element of planning. Although all responsible authorities carry out workforce surveys, the response rates vary from about 60 percent to almost 100 percent and the comparability and completeness of data also vary.

- 5.62 Closer working between the Ministry of Health and responsible authorities should ensure that response rates and consistency of data collection and analysis are improved across all professions. The Ministry may need to review the resources allocated to workforce data collection, collation, analysis and dissemination. The current powers in the Act may also need to be reviewed in order to ensure that all authorities collect and make available required information.

**Recommendation 14:** That, as part of national workforce planning, the Ministry of Health works with responsible authorities and other stakeholders to improve the collection, collation, analysis and dissemination of comprehensive, accurate, comparable, timely and non-identifiable information about the registered health practitioner workforce and advises the Government as to whether any increase in resources or legislative change is required to make those improvements.

## Chapter 6: Extension of the Act to Further Groups of Practitioners

- 6.1 This chapter deals with issues about when and whether further health services should be designated as health professions for the purposes of the Health Practitioners Competence Assurance Act 2003 and, if they are, how those professions should be regulated. As Cabinet directed, the issue of the proliferation of responsible authorities is also addressed.

### The provisions of the Act

- 6.2 Sections 115 and 116 of the Act deal with the issue of new professions. Section 115 gives the Governor-General the power by Order in Council, made on the recommendation of the Minister of Health, to designate a particular health service as a health profession. The Order in Council would either create a new responsible authority or add the new profession to the health professions for which an existing authority is appointed. In the latter case the name of the existing authority can be changed.
- 6.3 Section 116 sets out that before recommending a new profession for regulation, the Minister must, after consultation with any interested organisations, be satisfied that either:
- the provision of the health services concerned poses a risk of harm to the public, or
  - it is otherwise in the public interest that these services be regulated.
- 6.4 Section 116 also stipulates that the providers of the health services in question must be generally agreed on the:
- qualifications for providers
  - standards expected
  - competencies for scopes of practice.

### New services seeking to become regulated professions

- 6.5 Since the Act came into force in 2004, only psychotherapy has been added as a new health profession. An Order in Council to that effect was made on 21 May 2007 and came into force on 15 October 2007. The order established the Psychotherapists Board as the responsible authority.
- 6.6 At the time that the Health Select Committee was considering the Bill, the following groups made submissions expressing interest in becoming regulated:
- acupuncturists
  - ambulance officers
  - anaesthetic technicians
  - applied behaviour analysts
  - audiologists

- audiometrists
- cardiopulmonary technologists
- clinical perfusionists
- defence paramedics
- embalmers
- homeopaths
- hypnotherapists
- medical herbalists
- natural health practitioners (homeopathy, herbal medicine, naturopathy, remedial body therapy)
- radiation therapists
- social workers who work in health
- speech language therapists
- traditional Chinese medicine practitioners.

6.7 In addition to the above, the Ministry of Health has since been approached by the following health service providers about regulation under the Act:

- clinical physiologists
- conductive therapists
- counsellors
- health care assistants
- lactation consultants
- medical physicists
- music therapists
- pharmacy technicians
- renal technicians
- therapeutic massage practitioners.

6.8 Since 2004 the Ministry has consulted on whether there is a risk of harm to the public or it is otherwise in the public interest to regulate the following providers as a health profession under the Act.

- acupuncturists
- anaesthetic technicians
- clinical physiologists
- western medical herbalists
- psychotherapists
- speech language therapists.

6.9 The Minister of Health agreed that acupuncturists, anaesthetic technicians, psychotherapists and western medical herbalists should be regulated but so far only psychotherapy has progressed to the next step of making the regulation to appoint a responsible authority. The Ministry has also completed its consultation on clinical physiologists and speech language therapists but, because this review has been in process, the Minister has not yet been asked to make a recommendation about whether they should be regulated.

## Criteria for regulating a new profession

- 6.10 In regard to regulating new professions, the key criteria identified in section 116 are that the health services involve a risk of harm to the public or it is otherwise in the public interest to regulate. Risk of harm to the public could be interpreted as quite a low test given that any health service carries some risk of harm if performed inadequately. The costs of statutory regulation, however, are substantial and, as discussed in Chapter 1, occupational regulation by statute is not the only way to protect the public. Because the benefits of regulation must be matched against the costs, it is important to make some attempt to quantify the level of risk.
- 6.11 The Ministry of Health consulted on, developed and published a set of criteria for assessing applications for adding a health service as a new profession under the Act (see Appendix 7). These criteria require that a group of providers that is applying for regulation of a new profession sets out evidence:
- that the service is a health service
  - that the profession is identifiable
  - about the nature, frequency, severity and likelihood of risk of harm or of other factors that otherwise justify regulation
  - that there is general agreement on qualifications, standards and competencies
  - about proposals for the authority to be responsible for this profession and the associated costs.
- 6.12 The criteria also set out the process for the Ministry to consult on the proposal in order to be able to advise the Minister of Health on whether or not to act on the proposal. The consultation is designed to test the recommendations and claims made by the health service providers with stakeholders to determine whether the costs of regulation are matched by the benefits in terms of a higher level of health and safety for the public.
- 6.13 Although the Ministry's criteria document sets out the evidence that is to be supplied, it is not sufficiently explicit about the criteria that will be used to advise the Minister as to whether regulation is justified. The current Australian intergovernmental agreement for a national registration and accreditation scheme<sup>[18]</sup> includes a useful set of principles and criteria for this purpose (see Appendix 8). How to deal with this issue was also covered on pages 76–77 of the Ineson report.<sup>[6]</sup>

**Recommendation 15:** That the Ministry of Health examines and consults on criteria for statutory regulation of unregulated health occupations with reference to criteria such as those proposed for Australia.

## Why practitioners seek to become regulated professions

- 6.14 The list of occupational groups seeking to become regulated is quite extensive and covers most areas of health care work. In the course of the review it became evident that most of the occupational groups seeking regulation have a number of reasons for doing so and that concern over risk of harm to the public is commonly not the only or even the main driving force.
- 6.15 Professions that are regulated under the Act see themselves, and are seen by others, as having a status as a health profession that unregulated groups do not have. For the purposes of the Act, a health practitioner is interpreted as a person who is registered with an authority under the Act; and a health profession means a profession in respect of which an authority is appointed under the Act.
- 6.16 Occupations that are not among the list of traditional health professions may value registration because it gives them a legitimacy that they would otherwise not be able to claim. This situation perhaps applies to practitioners of a number of complementary and alternative health services. Osteopathy and chiropractic are registered under the Act but there is a range of other therapies and practices whose practitioners are not regulated. Practitioners of a number of these services have sought registration partly because they see there are potential risks to the public but also as a way of imposing some quality standards and as a way of gaining recognition and legitimacy.
- 6.17 The status of a profession can go further than merely how the profession is viewed by its members or others. Since the Act has come into force, it has been referenced by other legislation and by employers and others in the health system.
- 6.18 For example, the Accident Compensation Corporation (ACC) has recently consulted on a proposal to change the definition of health practitioners for the purpose of the treatment injury provisions of the ACC legislation.<sup>[32]</sup> The proposal would mean that patients of all practitioners recognised under the Health Practitioners Competence Assurance Act 2003 would be covered by the treatment injury provisions.
- 6.19 The same ACC discussion document also addresses the question of what counsellors need to do to be recognised as treatment providers for ACC payments. Some people offering counselling services belong to a profession that is regulated under the Health Practitioners Competence Assurance Act – and in this case ACC will only recognise and pay practitioners with current registration. Where counsellors belong to a group that is currently not regulated, ACC sets out particular expectations about qualifications, training and supervision – including recognising membership of certain professional associations. Thus ACC proposes to recognise statutory regulation for those counsellors who are in

regulated professions and recognises certain self-regulatory processes for other counsellors.

- 6.20 There are also examples where being a health practitioner regulated under the Health Practitioners Competence Assurance Act has become a requirement for employment and service provision. Setting this requirement is appropriate for professions that are covered by the Act. The situation, however, becomes less clear when the occupation in question is not regulated under the Act as is the case with speech language therapists and counsellors. Workers in drug and alcohol addiction services have for years been providing care for clients in a range of service settings but they are not regulated under the Act and some employers are now requiring that a registered practitioner from a different profession (who may in fact be much less experienced in this area) supervises them. The other side of this example is that some employers choose to use unregistered nutritionists rather than registered dietitians because in this way they avoid the costs involved with registration.
- 6.21 Some occupational groups wish to be registered because in many cases employers such as District Health Boards require and will pay or subsidise registration costs for regulated health practitioners but not for professions that are not regulated under the Act. This criterion can represent a significant financial incentive to seek recognition under the Act.

### **Expanding scopes of practice rather than designating new professions**

- 6.22 Section 115 of the Act envisages that regulating an additional health service involves designating them as a new health profession under the Act. An alternative approach is for the new service to become a scope of practice ('scope') within an existing profession with which it has an affiliation.
- 6.23 Examples of this approach exist particularly where professions have been developing levels of practice. The Nursing Council has developed an advanced scope, nurse practitioner, and an assistant scope, nurse assistant. The Pharmacy Council is currently developing four advanced levels of pharmacist and the Midwifery Council has consulted on a possible assistant scope of practice.
- 6.24 In the future it would be possible for other authorities to follow similar paths. The Medical Council, for example, might develop a physician assistant scope of practice and, if it were considered necessary to regulate pharmacy technicians, they could become a scope under the Pharmacy Council. A more radical development would be to regulate, for example, a range of different natural healing therapies as scopes of practice under a single professional responsible authority.

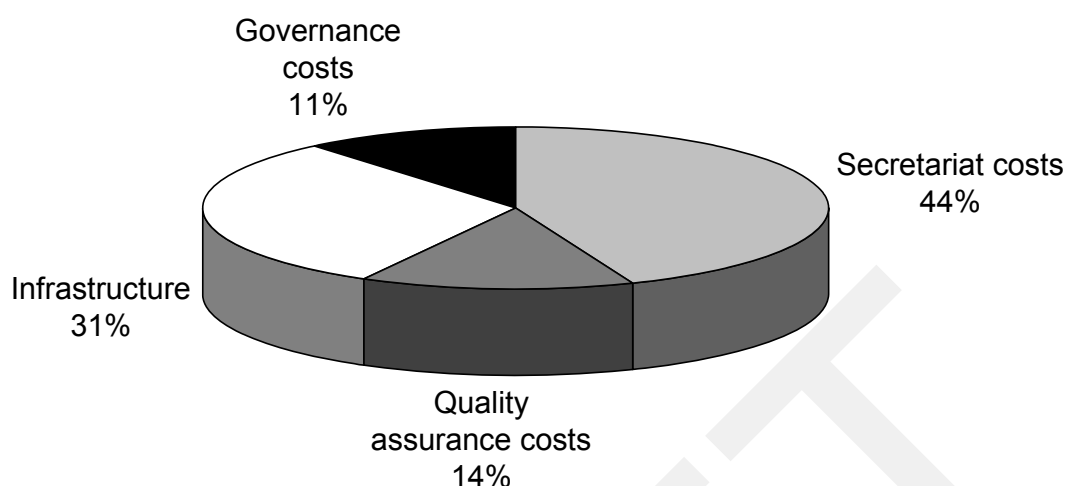
## Number and nature of responsible authorities

- 6.25 When in 2007 Cabinet agreed to the establishment of the Psychotherapists Board the costs of setting up a separate authority for a small group of practitioners was discussed. Alternative arrangements had been considered such as a single authority to cover psychologists and psychotherapists. Major differences in the approach of the two professions, however, meant that there were significant concerns that a joint body might be unable to agree on scopes of practice, qualifications or requirements for ongoing competence.
- 6.26 Cabinet approved the new authority but also asked that this review should address 'the proliferation of registration authorities'. The costs of setting up a separate authority each time a health service becomes designated as a health profession is a major concern. So too is the potential rigidity that may be introduced into health service delivery if different health services are each regulated by separate authorities.
- 6.27 In its submission to the review, District Health Boards New Zealand said:
- The unification of regulated occupational groups under a single piece of legislation is viewed as strongly positive ... in terms of its potential to enhance the flexibility of the health workforce. There is some concern that this potential of the Act may not be realized due to the number of responsible authorities and the lack of requirement for them to work together.<sup>[33]</sup>

## Costs of regulation

- 6.28 Costs for responsible authorities are significant and are a cost on practitioners through registration fees and disciplinary levies. Such costs are part of doing business and in turn they are passed on to the public and to employers. As such, they can affect fees or the cost of providing services.
- 6.29 The Ineson report<sup>[6]</sup> looked in more detail at the costs of running an authority. In addition, the review commissioned Ineson and Hyland, a management accountant, to attempt more detailed comparisons of authority costs.<sup>[34, 35]</sup> These costs vary considerably particularly in matters such as the number of complaints to be investigated, the need to establish competence reviews, and the approach to re-accreditation and assessment of overseas-trained practitioners. Figure 1, taken from Hyland's report and based on financial information from most authorities, gives an indication of the main areas of expenditure and their relative size.

**Figure 1:** Responsible authority expenditure groups



Source: Information supplied by 12 responsible authorities, May 2008, and reported by: Hyland D. 2008. *Review of Financial Statements of Responsible Authorities*. Wellington: Ministry of Health.

- 6.30 This analysis shows that governance costs are a small part of the costs of running an authority. The most important measure in terms of managing costs is to ensure that authorities collaborate and share administrative and secretarial costs.
- 6.31 Ineson's report looked at the level of annual practising fees compared with the number of registrants in various responsible authorities. Table 1 below shows that comparison for six professions in 2003/04 and 2006/07. It is clear that costs are higher for smaller professions.

**Table 1:** Comparison of responsible authority size and annual practising certificate (APC) fees

	2003/04		2006/07	
	No. practising	APC fee	No. practising	APC fee
Chiropractors	300	\$1100	354	\$1100
Dentists	1,630	\$650	1,966	\$700
Nurses	48,440*	\$50	44,646	\$96
Pharmacists	—**	\$610	3,091	\$495
Psychologists	1,404	\$455	1,732	\$595
Optometrists and dispensing opticians	695	\$560	674	\$560

Notes:

\* The 2003/04 annual report notes that 51,538 nurses and midwives had annual practising certificates.

\*\* This is the number registered in 2003/04, not the number of those with annual practising certificates.

### **Stand-alone authority for new profession**

- 6.32 The simplest but probably the most expensive option is to establish a new responsible authority for the new profession. This may be the appropriate option where the newly regulated profession is very significantly different from all existing professions and where the number of likely registrants allows costs to be shared widely.
- 6.33 If the establishment of a new authority is under consideration, the group involved should be asked to provide a detailed business plan and budget beforehand. There should be a clear expectation that the new authority shows it intends to constrain costs by sharing infrastructure and administrative costs with other authorities. With appropriate sharing arrangements for other costs, the modest additional costs of governance of a separate authority may be justifiable.

### **Authorities covering several professions**

- 6.34 Currently two authorities cover more than one profession (see Appendix 4) – the Dental Council, and the Optometrists and Dispensing Opticians Board. In both cases it has taken time to establish appropriate board structures. Moreover, some submissions suggest that there are still ongoing tensions and issues between the Dental Council and some of its professions.
- 6.35 Although they may involve some difficulties, these arrangements also offer clear advantages. Where practitioners or the services they provide are closely related, there can be significant advantages in having a single body with a consistent and well-informed approach to scopes of practice, qualifications, requirements for competence, and standard setting. The challenge will be ensuring that all the various professions have confidence in the authority's decision-making in regard to their individual profession.
- 6.36 In these circumstances, the best structure for the governing board may vary depending upon the size and nature of the professions involved. It may be that, a very small board is not suitable but, representing each separate profession on the board may not be appropriate; particularly as members of an authority's board need to be focused on protecting the public, rather than representing a profession.
- 6.37 Given the current and future mix of professions, it may make sense for more authorities to cover a number of similar professions. Examples of the application of this approach in other countries include authorities that cover speech and hearing practitioners in various Canadian provinces; osteopaths and chiropractors in Australia's Northern Territory; a mental health practitioners board covering four professions in New York State, United States of America; and a board for Chinese herbal medicine practitioners and acupuncturists in Victoria, Australia. The United Kingdom's Health Professionals Council currently regulates 13 health professions; and in Ireland the Health and Social Care

Professionals Council regulates 12 professions, each of which has its own registration board under the council.

- 6.38 In New Zealand, with the small number of practitioners in many professions, the costs associated with smaller authorities and the significant number of new professions that may need to be regulated, the possibility of joint authorities has already been considered. The recently formed Psychotherapists Board is in discussions with the counsellors who are seeking regulation. Similarly an authority could cover a number of complementary and alternative therapies such as acupuncture, Chinese medicine, homeopathy and natural health, possibly along with the existing regulated professions of osteopathy and chiropractic. A technical health professions authority might encompass anaesthetic technicians, renal technicians, cardiopulmonary technologists, clinical perfusionists, and medical physicists, perhaps along with one or more existing authorities. Alternatively, many of these professions might be seen as assisting medical practitioners and therefore might be regulated under the Medical Council.
- 6.39 Instituting one or more of these arrangements and possibly others might require changes to existing authorities in the future. At present, although the Minister of Health has the power by Order in Council to establish a new profession and to change an existing authority to encompass the new profession, a change in the law would be required to allow the merger of two or more existing authorities. This situation seems anomalous and does not appear to have been discussed at the time of the Health Select Committee hearings in 2003. This review recommends that the Act is amended accordingly.

**Recommendation 16:** That section 114 of the Health Practitioners Competence Assurance Act 2003 is amended to give the Minister the power by Order in Council to join and restructure two or more existing authorities in situations where, after consultation, the Minister is satisfied that it is in the public interest to do so and that the authorities and their professions are generally in agreement.

### **Shared secretariats and infrastructure but separate governance boards**

- 6.40 As described previously (paragraph 4.32) a number of authorities are already sharing services. There are also examples of one authority providing particular services to others. The Medical Council provides human resources services to a number of other authorities and also provides the secretariat services for the Health Practitioners Disciplinary Tribunal. These arrangements of contracting particular services may in the future become more common as particular authorities develop skills and systems that others wish to use.

**Recommendation 17:** That the Ministry of Health reviews the process for groups seeking to have a new health service regulated as a profession in order to gather full information with which to advise the Minister of Health as to whether statutory occupational regulation

is recommended and, if so, what arrangements are best for appointing a responsible authority in respect of that profession.

**Recommendation 18:** That, after this report has been tabled in the House of Representatives, the Ministry of Health moves rapidly to make recommendations to the Minister of Health in respect of those groups for which it has already been decided that statutory regulation under the Health Practitioners Competence Assurance Act 2003 is appropriate.

DRAFT

## Chapter 7: Complaints and Disciplinary Matters

- 7.1 This chapter covers complaints and discipline. Part 4 of the Health Practitioners Competence Assurance Act 2003 deals with these matters under the subheadings of referral of complaints and interim suspensions; professional conduct committees; the Health Practitioners Disciplinary Tribunal; procedures and decisions of the tribunal, and funding of the tribunal; and recovery of costs and fines.
- 7.2 The purpose of these provisions was to ‘provide consistent, co-ordinated, fair, and transparent processes for handling complaints against health practitioners’.<sup>[12]</sup> In general terms the review finds that these provisions are working as Parliament intended. Those making submissions, particularly responsible authorities, the Health and Disability Commissioner and the Chair of the tribunal, have identified a number of mostly minor issues in relation to some of the provisions relating to complaints and discipline.

### Referral of complaints

- 7.3 Section 64 of the Act is designed to ensure that any complaint that involves a consumer is dealt with in a consistent manner as a possible breach of the Code of Health and Disability Services Consumers’ Rights. When a responsible authority receives a complaint alleging that a practitioner’s conduct has affected a health consumer, the authority is required to forward the complaint to the Health and Disability Commissioner, who will investigate. Under section 34(1)(a) of the Health and Disability Commissioner Act 1994, after a preliminary assessment, ‘if it appears from the complaint that the competence of a health practitioner or his or her fitness to practise or the appropriateness of his or her conduct may be in doubt’, the Commissioner may refer the complaint back to the authority. This system is working well.
- 7.4 At least one authority has faced a legal challenge to its receiving complaints and taking action concerning a matter that has not affected a consumer. The authority has asked under what provision of the Act such a complaint would be made and action taken. In addition, the question has arisen as to whether a complainant is protected in the same way that sections 34(4) and 45(6) protect against civil or disciplinary proceedings against anyone giving notice that a practitioner is possibly incompetent or unfit practice. Parliament clearly expected that responsible authorities would receive complaints about practitioners from time to time and Part 4 of the Act sets out various procedures for dealing with such complaints. It would be appropriate, therefore, section 118 of the Act to explicitly specify that one function of authorities is to receive and take appropriate action on complaints about a practitioner’s conduct to. Likewise, it would be appropriate for Part 4 to accord to complainants who act in good faith a protection against civil or disciplinary proceedings.

**Recommendation 19:** That sections 64 and 118 of the Health Practitioners Competence Assurance Act 2003 are amended to specifically recognise that it is a function of responsible authorities to receive complaints about the appropriateness of a practitioner's conduct and to protect complainants against civil or disciplinary proceedings unless they have acted in bad faith.

- 7.5 Under section 65, when an authority receives a complaint referred from the Health and Disability Commissioner it must assess the complaint promptly and choose what action to take. One of these possible actions is to send the complaint for consideration by a professional conduct committee (see paragraph 7.15 for further discussion about these committees). Under section 67, authorities also receive notification from the courts when a health practitioner is convicted for certain offences and all such notices must be referred to a professional conduct committee. Finally, under section 68(3), if an authority has information that raises a question about the appropriateness of a practitioner's conduct or practice it may refer this information to a professional conduct committee.
- 7.6 Responsible authorities have a number of options as to how they will deal with complaints that raise questions about the appropriateness of a practitioner's conduct – regardless of where these questions arise. In some cases there may be questions about competence or fitness to practise that are best dealt with under the relevant provisions in Part 3 of the Act; some issues should be dealt with by an employer, or referred to the police or another agency. Although one option is referral to a professional conduct committee as noted above, a number of authorities have found that other courses of action may be more effective and appropriate in some cases. Authorities could usefully learn from others about best practice in this area.
- 7.7 In its submission, a responsible authority asks whether the authority can refer a complaint to a professional conduct committee when the Health and Disability Commissioner has closed the case without referring the complaint to the authority. It was the intention of the Act that the Commissioner would deal in a consistent way with all complaints alleging that a practitioner's conduct had affected a consumer, as possible breaches of the Code of Health and Disability Services Consumers' Rights. But the professional bodies have a different mandate and an authority may establish a professional conduct committee on receipt of a complaint (section 65) or of its own volition (section 71). Section 70 merely suspends any disciplinary action by a responsible authority until the Commissioner's complaints process is completed. It does not prohibit an authority from dealing with a complaint in the professional disciplinary context after it is disposed of by the Commissioner in terms of the Code.

- 7.8 Section 68(2) requires that authorities refer all notices they receive about convictions of health practitioners to a professional conduct committee as soon as reasonably practicable. Authorities have asked whether there should be some discretion allowed for the authority's board or Registrar to consider minor offending. Although a conviction punishable by a prison term of three months or longer is unlikely to be considered minor, the review agrees that there may be some offences against the 12 specific Acts listed in section 67 that would be considered minor and for which the time and expense involved with a professional conduct committee may not be justified.

**Recommendation 20:** That section 68(2) of the Health Practitioners Competence Assurance Act 2003 is amended to give responsible authorities discretion whether to refer practitioners who have been convicted under a minor offence listed in section 67(b) to a professional conduct committee.

### Interim suspensions

- 7.9 Section 69 gives the authority power to suspend a practitioner's practising certificate pending criminal proceedings or an investigation under the Health and Disability Commissioner Act 1994. Such suspension requires that the authority on reasonable ground is of the opinion that the alleged conduct 'casts doubt on the appropriateness of the practitioner's conduct in his or her professional capacity'.
- 7.10 There are four other places in the Act referring to interim suspension: section 39(2) (for incompetence posing risk of serious harm to the public); section 48(2) (where the authority considers the practitioner is unable to perform the functions needed for practice because of mental or physical condition); section 79 (where a professional conduct committee has reason to believe that there is a 'risk of serious harm to the public'); and section 93 (where the Health Practitioners Disciplinary Tribunal has the power to suspend where it 'is satisfied it is necessary or reasonable to do so, having regard to the need to protect the health or safety of members of the public').
- 7.11 Some submissions proposed that the wording in sections 69 and 93 be aligned with that in sections 39(2) and 79. In other words, they argued that interim suspension should require that there are reasonable grounds for believing that the practitioner's conduct poses a serious risk of harm to the public. This alternative approach would seem to be more consistent with the principal purpose of the Act, namely to protect the health and safety of members of the public.

**Recommendation 21:** That sections 69 and 93 of the Health Practitioners Competence Assurance Act 2003 is amended to restrict interim suspension to situations where there are reasonable grounds to believe that a practitioner's conduct poses a risk of serious harm to the public.

- 7.12 Some submissions asked that the term 'risk of serious harm' be amended to 'serious risk of harm'. The use of the term 'risk of serious harm' is restricted in the Act to the occasions when interim suspension is under consideration. It is clear that the intention was only to use this power to protect the public from significant harm. To show that the public is at risk of serious harm, the authority needs to have reasonable grounds to believe that (a) there is a serious risk that the conduct may occur and (b) if the conduct occurs it may lead to serious harm. If the wording was changed to 'serious risk of harm' then it would be possible for an interim suspension to be based on conduct that, while likely to occur, would not give rise to serious harm.
- 7.13 According to paragraph 17(1) of Schedule 3 to the Act, the power to suspend a practising certificate in section 69 cannot be delegated to a committee or to the Registrar. (Similarly the section 71 power to appoint professional conduct committees cannot be delegated – see paragraph 7.15.) However, interim suspension for incompetence or for health reasons in Part 3 can be delegated. It is unclear why the powers in Part 4 cannot similarly be delegated. Flexibility of this sort would help to speed up processes in an area regarding which the review has heard considerable concerns about timeliness. 0 addresses this issue.
- 7.14 Some responsible authorities have stated that there are occasions where they need to be able to move quickly to suspend a health practitioner whose conduct may be posing a risk of serious harm. They contend that the provisions in section 69(3) by which they are first required to inform the practitioner and allow a reasonable opportunity for the practitioner to make written submissions and be heard means that the public may, in the meantime, continue to be at risk. The review finds that these provisions were inserted by Parliament because it was considered to be not appropriate to give an authority such powers to act without notice. Suspension, especially if done without notice, involves a significant curtailment of individual rights and freedoms and would have New Zealand Bill of Rights implications. The current provisions permitting suspension appropriately balance the individual practitioner's rights and freedoms and the public interest, and an amendment as suggested is not warranted at this time.

## **Professional conduct committees**

- 7.15 Authorities may appoint professional conduct committees under section 71 of the Act. A professional conduct committee consists of two professional peers and one layperson. As the name implies, a committee of this nature is established to look into matters concerning the appropriateness of the practice or conduct of a health practitioner – whether or not these matters were directly related to a consumer. The review finds that generally these committees are working well though they are costly and time consuming, and sometimes it takes a long time for a complaint to reach the committee concerned.

- 7.16 Section 71 stipulates that only the responsible authority can appoint the members of a professional conduct committee. This requirement has on occasions slowed down the process of setting up a committee, for example, in the case of sudden illness of a committee member. Submissions have asked whether the committee appointment could be delegated to allow the authority's Registrar to choose members or to choose members from a panel that the authority has appointed. Paragraph 17 of Schedule 3 specifically prohibits such a delegation, presumably because the powers of a professional conduct committee allow it to have a major impact on a practitioner's livelihood. The review, however, has heard a significant number of complaints about the time taken for these proceedings. Some flexibility in appointing members would help accelerate this process. Any risks associated with greater flexibility are modified by the power in section 75 for practitioners and/or complainants to challenge the membership of the committee.

**Recommendation 22:** That paragraph 17 of Schedule 3 to the Health Practitioners Competence Assurance Act 2003 is amended to allow the responsible authority to delegate any of its functions, duties or powers to a committee or to its Registrar.

## Health Practitioners Disciplinary Tribunal

- 7.17 The Act established a tribunal known as the Health Practitioners Disciplinary Tribunal 'to hear those complaints against health practitioners that warrant significant disciplinary action'.<sup>[12]</sup> The tribunal hears and determines charges brought against a health practitioner by either the Director of Proceedings under the Health and Disability Commissioner Act 1994 or by a professional conduct committee. In her report *Review of Processes Concerning Adverse Medical Events*,<sup>[36]</sup> Helen Cull QC recommended this structure of a single tribunal. The Health Select Committee did, however, modify her original proposal in order to ensure adequate professional representation on hearings and to control costs.
- 7.18 In general the Health Practitioners Disciplinary Tribunal is working well and the separation of the disciplinary powers from the responsible authority's functions is operating as Parliament intended. The review agrees with the Chair of the tribunal when he wrote of the tribunal, 'It ensures that whereas formerly there were multiple statutes and multiple different approaches to discipline, now consistency of approach can be maintained in the regulation of health sector professionals.'<sup>[37]</sup>

## Appointment of tribunal members and multi-professional cases

- 7.19 The review received a few comments about the appointment process for the panel of laypeople and health practitioners that, under section 87 of the Act, the Minister of Health must maintain. Actions for improvements in this area, along with those in the area of appointments to responsible authorities, have been covered in Recommendation 9.

7.20 The review received a significant number of submissions concerning the need for a multidisciplinary tribunal that could consider a case where a multi-professional team was involved. One such proposal came from the Health and Disability Commissioner. The Chair of the tribunal notes that so far no such case has arisen. The power to establish a larger tribunal that includes a mix of professionals would be one way to address such a case. A mixed-profession tribunal, however, would bring its own complexities as to the number and mix of lay and professional members and it could give rise to issues when a practitioner was being judged by practitioners from professions other than their own. At this point the review does not favour a legislative amendment to address such cases, which are expected to be unusual.

### **Amendments concerning procedures of the Health Practitioners Disciplinary Tribunal**

7.21 The Chair of the tribunal, in his submission to this review,<sup>[37]</sup> proposed that there should be an amendment to allow the Chair alone to issue an order for non-publication of material in cases where all parties agree.

**Recommendation 23:** That section 95 of the Health Practitioners Competence Assurance Act 2003 is amended to allow the Chair of the Health Practitioners Disciplinary Tribunal to issue, on his or her own, an order for non-publication of material in circumstance where all parties to a hearing consent to the non-publication order.

7.22 A case that was appealed to the High Court raised the question as to whether the power to apply conditions on practice under section 101(1)(c) was only available if there was also an order for suspension of registration. The Review agrees with the Chair of the Tribunal that this was not the intention of the legislation and a clarifying amendment would be useful. That section 101(1) is clarified to ensure that penalties imposed by the Health Practitioners Disciplinary Tribunal can each be applied independently of whether or not other penalties have also been applied.

7.23 Section 102 of the Act sets conditions for re-entry to the register after a practitioner's registration has been cancelled. The Chair of the tribunal<sup>[37]</sup> notes that on several occasions the tribunal has wished to set a minimum period before which a practitioner could not apply for re-registration, but the tribunal has not had the power to set this condition. He also notes that the Medical Practitioners Act 1995 allowed such a power and recommends that there should be the ability to fix a minimum period before which a health practitioner could not apply for re-registration. The Chair states that he 'is aware of one situation where a practitioner attempted to action an application for re-registration, the day after an order of cancellation had been made'.

- 7.24 The original Bill presented to the House in 2002 reflected the Medical Practitioners Act 1995 and contained a power of the kind the Chair of the tribunal recommends.<sup>[12]</sup> From the Ministry of Health's Departmental Report to the Health Select Committee in 2002,<sup>[38]</sup> it seems that it was the Medical Council that recommended removing this power and limiting the tribunal to making orders that a practitioner must meet before being allowed to apply for re-entry to the register. The Departmental Report supported the removal on the grounds that the provision allowing the tribunal to set a time limit 'seems to be simply punitive'. The Health Select Committee in its report to the House recommended removal of the power from the Bill without any explanation.
- 7.25 The review finds that on this issue the experience of the Health Practitioners Disciplinary Tribunal should be given some weight. There could be situations where it is appropriate for the tribunal to decide that a certain time should pass before a practitioner is allowed to apply for re-entry to the register. It may make this judgement because, after the set time has elapsed, the responsible authority will have more information on which to base a decision about re-registration. Alternatively the reason for the decision may be that removing the practitioner from the register is part of the penalty for an offence. Under section 101(1)(b) the tribunal has the power to order suspension of registration 'for a period not exceeding three years'. It seems inconsistent that the tribunal lacks a similar power to set a timeframe for cancellation of registration.

**Recommendation 24:** That section 102 of the Health Practitioners Competence Assurance Act 2003 is amended to enable the Health Practitioners Disciplinary Tribunal to set a minimum period before which a health practitioner whose registration has been cancelled cannot apply for re-registration.

- 7.26 The Chair of the Tribunal asks that there should be provision for the Tribunal to advise any employer of the Tribunal's orders. However, while there are a number of cases that would support such notification, it is equally the case that such notification may involve an unwarranted and unfair disclosure of information. and the Review agrees with this. Requiring the Tribunal to be satisfied that such disclosure is in the public interest as a threshold test would appropriately balance these competing interests.

**Recommendation 25:** That section 103 of the Health Practitioners Competence Assurance Act 2003 is amended to give the Health Practitioners Disciplinary Tribunal the power to instruct the appropriate executive officer of the Tribunal to notify any employer of orders of the Tribunal if the Tribunal is satisfied that such disclosure is in the public interest.

- 7.27 Section 6(5) of schedule 1 of the Act refers to the Evidence Act 1908 but this should be updated to refer to the 2006 Act.

**Recommendation 26:** That section 6(5) of Schedule 1 of the Health Practitioners Competence Assurance Act 2003 is amended to bring it into line with the repeal of the Evidence Act 1908 and the enactment of the Evidence Act 2006.

## **Funding and operating the Health Practitioners Disciplinary Tribunal**

- 7.28 Section 104(1) of the Act establishes that for each proceeding against a health practitioner, the relevant responsible authority pays the costs and provides premises and support. Section 104(2) requires each authority to appoint one person to be the Health Practitioners Disciplinary Tribunal's executive officer for proceedings against any health practitioners from the profession for which that authority has responsibility. Under these arrangements, authorities that have few or no cases are not required to pay for running of the tribunal.
- 7.29 Since the Act came into force, all but three of the authorities have agreed to contract the Medical Council's executive officer to be the executive officer for their authority as well. The three that have not so far contracted out the executive officer function are small professions that have never had a case go to the tribunal.<sup>7</sup> The Health Select Committee envisaged sharing of the kind being undertaken by the majority of authorities when it recommended changes to the original Bill.<sup>[11]</sup>
- 7.30 In 2004 the authorities agreed a memorandum of understanding with the tribunal. That memorandum established, among other matters, the tasks of executive officer, the rates of payment for tribunal members, and how to fund the running costs of the tribunal.
- 7.31 When the tribunal was initially established, its Chair and the responsible authorities agreed that tribunal members should receive training about their roles and about hearings. For the initial establishment phase, the Minister of Health granted some funding for members' training. The authorities, as part of the memorandum of understanding, agreed on a formula to also fund day-to-day running costs associated with the tribunal.
- 7.32 In 2007 the Chair of the tribunal saw a need for further training for tribunal panel members because there were both new panel members and some members who had experienced few or no hearings and needed renewal of training. At this time some authorities sought legal advice about whether funding of these running costs was a legitimate use of their funds – and received advice that the Act as it is currently written does not allow for use of their funds in this way.

<sup>7</sup> The Chiropractic Board, the Dietitians Board and the Podiatrist Board.

- 7.33 However, it was the clear intention of Parliament that the responsible authorities would cover all of the costs of the tribunal (as had previously been the case; prior to the enactment of this Act all of the professional bodies established and maintained their own professional disciplinary entities). There is no indication in the Act or in the deliberations of the Health Select Committee of any intention that the Crown should contribute to the funding of the tribunal, which after all, merely replaced the existing disciplinary structures. For example, the Health Select Committee referred only to the role of the Chairs of responsible authorities in fixing the fees for the Chair and Deputy Chairs of the tribunal.
- 7.34 There is also the potential for any external funding to operate as a perverse incentive for the responsible authorities. That is, because the various professions are responsible for funding the tribunal their interest in maintaining professional quality, safety and standards through the processes and mechanisms otherwise provided for in the Act and maintaining the tribunal as a backstop, or 'last resort' mechanism is encouraged, i.e. the primary responsibility for maintaining professional quality and standards resides with the responsible authorities.

**Recommendation 27:** That section 104 of the Health Practitioners Competence Assurance Act 2003 is amended to clarify that responsible authorities are responsible for paying running costs of the Health Practitioners Disciplinary Tribunal, including costs not directly related to individual hearings and the costs of training tribunal panel members.

- 7.35 A number of submissions proposed that the current arrangement, whereby the Health Practitioners Disciplinary Tribunal is served by executive officers appointed by each authority, should be replaced by a permanent and independent secretariat. The Chair of the tribunal promoted this option and suggested a permanent staff of six people.<sup>8</sup> Such an arrangement would have a number of advantages but would also add to the costs of running the tribunal – costs that would then be passed on through authorities to the practitioners, their clients or employers. It was concern about costs that led to the arrangements that are currently in the Act.
- 7.36 It is noteworthy that most responsible authorities have co-operated with each other in contracting with the Medical Council to use the services of the council's executive officer. This arrangement has established a form of single secretariat – albeit with the staff employed by the Medical Council. The review finds that it is currently more consistent with Parliament's intent to allow authorities to continue to operate arrangements that they have worked out between themselves than to legislate to impose a single, completely independent secretariat. If further changes are needed, they should be discussed between authorities and the tribunal Chair.

<sup>8</sup> The Medical Council currently employs two full-time and one part-time executive officers and a personal assistant. The council provides other services that would be needed by a totally independent secretariat.

## Chapter 8: Protected Quality Assurance

8.1 This chapter deals with sections 52 to 63 of the Health Practitioners Competence Assurance Act 2003, which concern quality assurance activities. Specifically these sections:

enable the Minister to confer protection on quality assurance activities conducted to improve the practices or competence of health practitioners and so protect the confidentiality of information that becomes known solely as a result of those activities and give those engaged in those activities immunity from civil liability.<sup>[39]</sup>

8.2 In general the review finds that the protections afforded by the Act are valuable and have encouraged quality assurance activities as intended, though so far they have not been used as widely as might have been expected. There are, however, aspects of the current provisions that submissions to this review have questioned. This chapter recommends a number of legislative changes to improve their operation.

8.3 It is also noteworthy that over recent years the approach to health service quality and safety has increasingly emphasised the disclosure of adverse events so that system improvements can be made. Protected quality assurance activities can play a part in this approach though they may in time become unnecessary as practitioners gain trust in processes of more open disclosure.

### Background

8.4 Quality assurance activities were first protected in New Zealand for medical practitioners under the Medical Practitioners Act 1995. The Health Practitioners Competence Assurance Act 2003 extended the arrangements to other health practitioners.

8.5 The provisions in sections 52 to 63 of the Act provide a degree of qualified privilege to quality assurance activities.<sup>9</sup> Sponsors of quality assurance activities may apply for the Minister of Health to declare an activity a quality assurance activity for the purpose of the Act. Once an activity has been so declared, the Act:

- protects the confidentiality of:
  - information that becomes known solely as a result of such activities
  - documents brought into existence solely for the purposes of such activities
- gives immunity from civil liability to people who engage in such activities in good faith.

<sup>9</sup> The equivalent Australian provision is called the Commonwealth Qualified Privilege Scheme and is included as Part VC of the Health Insurance Act 1973. The quality assurance provisions in the Medical Practitioners Act 1995 were based on these Australian provisions. There appear to be no qualified privilege schemes of this sort outside Australia and New Zealand.

- 8.6 The quality assurance provisions of the Health Practitioners Competence Assurance Act 2003 are different in a number of ways from those in the Medical Practitioners Act 1995. Subsequent influences that shaped the 2003 Act's provisions were the Director-General of Health's 1999 review of the provisions in the Medical Practitioners Act 1995,<sup>[40]</sup> as well as submissions and considerations during the passage of the Health Practitioners Competence Assurance Bill through the House of Representatives in 2003.
- 8.7 The new provisions that had not featured in the Medical Practitioners Act 1995 were the Bill's most contentious ones during its passage through the House in 2003. In particular there was debate about whether and how the quality assurance protections should apply to inquiries into serious adverse events, whether appointing an independent person to be responsible for each quality assurance activity would work, and whether the new and extended reporting requirements were useful. These issues are dealt with in more detail below.

## Overall findings

- 8.8 Most submissions to the review did not respond to the questions about quality assurance activities. Similarly at workshops in April and September 2008 many participants were unaware or had no experience of the quality assurance provisions in the Act. The nature of this feedback bears out a general finding that, despite the broadening of provisions to all health practitioners, it is still largely medical practitioners or services that involve medical practitioners that use the protection for quality assurance activities.
- 8.9 Most of the submissions that addressed the quality assurance protections were supportive of their retention as an important and useful part of addressing the quality and safety of a practitioner's practice and the health services they provide. Most of these submissions, however, also noted that certain aspects of the provisions were difficult, unclear or unnecessary. These aspects are dealt with in more detail in the following sections.
- 8.10 A few submissions and some comments at the workshops (including comments at a specific workshop in September 2008 on this part of the Act) addressed the issue of how these provisions fitted with other and newer processes for addressing health system quality. One particular new process of note is the Quality Improvement Committee (renamed in 2007 as a continuation of the former National Health Epidemiology and Quality Assurance Advisory Committee which is established under the New Zealand Public Health and Disability Act 2000).
- 8.11 One of the Quality Improvement Committee's five key projects is the National Healthcare Incident Management programme for public hospitals. This programme aims to develop 'a systematic approach to identifying and analysing common causes of system failure'. The committee notes that 'the right culture and environment' is needed and that 'a fundamental component of the culture that is to be achieved is one that is caring and compassionate and one in which the disclosure of adverse events is open and truthful'.<sup>[41]</sup>

- 8.12 At the workshop held to review the quality assurance provisions of the Act, some participants commented that most of the quality processes operating in their organisations under this Healthcare Incident Management programme – and many others already established quality processes – had not been submitted for protection under the Act yet practitioners were still fully co-operating. Other participants said that most of their programmes did operate under a designated, protected quality assurance programme and they thought the protection afforded in that way was important.
- 8.13 A few submissions presented the view that the quality assurance protections of the Act are inappropriate or are being too widely applied. The Health and Disability Commissioner noted that, under the Code of Health and Disability Services Consumers' Rights, consumers have a right to open disclosure of any adverse events in their health care and that widespread use of protected quality assurance activities may conflict with that right. The Commissioner referred to reports of patients being excluded from discussions and investigations about events involving them because those events were part of a protected quality assurance activity. Where a Notice has been improperly invoked Ministers of Health have written to District Health Boards to confirm that QAA Notices may not be used to prevent disclosure of information relating to serious adverse events, particularly where such disclosure is in the public interest.
- 8.14 The review finds that overall the provisions in the Act are a useful part of a broader set of programmes and activities designed to improve the quality and safety of health services. The increasing and appropriate use of open disclosure should be encouraged and may, in time, reduce the need for the protections that the Act provides.

### **Investigation of serious adverse events**

- 8.15 In 1999 the Director-General of Health reviewed Part VI (the quality assurance provisions) of the Medical Practitioners Act 1995.<sup>[40]</sup> As a result, the Ministry of Health recommended that the Health Practitioners Competence Assurance Bill should specifically exclude 'specific significant incidents', and an exclusion was part of the Bill as introduced to the House in 2002.<sup>[12]</sup> This provision was removed following the Health Select Committee's consideration of the Bill. The committee introduced a new section under which activities would not be protected if at the same time they were part of an inquiry or investigation. This new provision was struck out when the Bill was being considered during the committee stages. Under a Government Supplementary Order Paper, section 53(2)(c) was added to the final Act. This provision states that information is not protected if the purpose of its disclosure as part of a protected quality assurance activity was wholly or partly to try to prevent its disclosure in an investigation when the person has already been requested to respond to an investigation.

- 8.16 It seems from this history, and from the nature of the debate at the time, that Parliament supported the use of protected quality assurance activities to look at adverse events. Indeed, many quality assurance activities specifically include the consideration of adverse events because much can be learned from them. However, the protections are not to be used as a way of preventing proper disclosure of information in other contexts, or to prevent 'due process' under other statutory provisions and processes. Similarly, although section 62 gives immunity from civil or disciplinary proceedings for a person engaged in a quality assurance activity, that immunity only applies if the person was engaged 'in good faith'.
- 8.17 There are provisions in section 60 of the Act that set down certain exceptions to the prohibition of disclosure of information. In addition, section 61 grants the Minister of Health power to authorise disclosure of protected information to an investigation if he or she is satisfied that it relates to a serious offence. That power has not yet been used.
- 8.18 Considerations of protected quality assurance activities highlight the tension between the need for open disclosure to engender public confidence in the health system and the need to provide an environment where practitioners may engage in and learn from near misses and adverse treatment outcomes. The review does not recommend revisiting the current legislative provisions in respect of how protected quality assurance activities apply where there are investigations of serious adverse events. Similarly the review makes no recommendation that it is generally necessary to protect activities related to processes like the Healthcare Incident Management programme.

## **Responsible persons**

- 8.19 The Act requires that the Minister must appoint a person who is to be responsible for each protected quality assurance activity. That person is responsible for reporting about the activity on a six-monthly basis to the provider of services, and each year must report to the Minister and to the activity's sponsor.
- 8.20 The sponsor of the activity nominates the responsible person when applying to have the Minister declare that activity as a quality assurance activity. The person must be someone who is independent of the health practitioners who are covered by the quality assurance activity.
- 8.21 Experience reported by a number of organisations, including District Health Boards, is that the requirement for independence from those involved with the activities can be difficult to meet, especially when the activity is managed outside the auspices of a hospital institution.
- 8.22 The review finds that the concept of appointing an independent person to be responsible for each activity is useful and desirable but the practical difficulties mitigate against this and the Act should be amended accordingly.

**Recommendation 28:** That section 55(3)(a) of the Health Practitioners Competence Assurance Act 2003 is amended so that a person responsible for quality assurance activities is not required to be independent of the activity.

## Reporting requirements

- 8.23 The person who is appointed as responsible for each quality assurance activity is required to report every six months to the provider of the health services associated with the activity. Once a year the responsible person must also give the same information to the Minister of Health and the sponsor of the activity but without identifying any particular individuals. Each report must cover:
- any problems concerning the operations of the provider
  - actions that have been taken to address the problems
  - any recommendations to the provider
  - how recommendations will be monitored
  - how improvements in the competence or practice of the provider or provider's employees or agents will be monitored.
- 8.24 The purpose of the reporting requirements was to ensure that when the need for changes was identified, it would be acted on and also there was some oversight at the national level to ensure that the scheme was working properly as intended. It was also thought that national reporting of local findings would be able to be collated as useful learning that could be disseminated to other providers.
- 8.25 The review heard that reports varied widely in quality and completeness. In most cases it seems that reporting is seen as a required process that gives some level of accountability that quality assurance activities are continuing but provides little detail about findings. In larger organisations the responsible person may cover a wide number and range of quality assurance activities and does not have the time or resource to do more than report on the process rather than the detail.
- 8.26 The Ministry of Health collects reports on behalf of the Minister of Health and has developed a template for that purpose. The template asks for a short report on the nature of the activities, the extent to which practitioners participated, the ways that findings were disseminated and any evidence of improvements as a result. The main purpose has been to enable the Minister to judge whether it is still in the public interest to declare the activity as a quality assurance activity. Most reports contain insufficient detail about services and cannot be used to help disseminate learning or recommendations for others. For example, many reports simply state that problems were identified and action taken to rectify them – giving no details about the nature of the problems. The Ministry has not attempted to use the information received to disseminate any learnings nationally.

- 8.27 Moreover, protected quality assurance activities form only a subset of all the quality assurance activities that are taking place around the country, so any national reports that were based on the protected activities would be incomplete. The new programmes that are being developed under the auspices of the Quality Improvement Committee may be a better way to disseminate learning. It may be that in the future, non-identifiable reports from protected quality assurance activities should be incorporated into those new programmes.

**Recommendation 29:** That section 58 of the Health Practitioners Competence Assurance Act 2003 is amended to simplify and reduce the administrative burden of the reporting requirements for quality assurance activities.

## Other issues

- 8.28 In their submissions, several national medical organisations raised questions about how the provisions in the Act are expected to operate when quality assurance activities are carried out at the national level rather than locally. Such national activities, for example, collect data about anaesthetic practice, collate them with data from other New Zealand practitioners (and sometimes with Australian data) and then return an individual's data compared with the national dataset. The submitters' questions concerned how to identify a responsible person in such cases and how to report on action that the individual might take as a result of the activity.
- 8.29 The Ministry of Health held up some applications for renewal of quality assurance activity declarations for national programmes of this nature, in order to ensure that those activities complied with the requirements under the Act. The Ministry has now clarified that activities are eligible to be declared quality assurance activities whether they are local or national. The questions about responsible persons and reporting have been addressed under Recommendations 28 and 29.
- 8.30 Another question that has arisen is whether or not the provisions for exclusion of liability for quality assurance activities extends to people who are not registered practitioners – social workers have been mentioned as a particular case of relevance. On this point the Act is clear. An activity can only be declared a quality assurance activity if it is undertaken to improve the practices or competence of one or more health practitioners but, once such an activity is declared, the protections for exclusion of liability are, according to section 62, afforded to 'any person in respect of conduct engaged in good faith in connection with a protected quality assurance activity'.
- 8.31 The same protection is afforded to all information provided in the course of such a quality assurance activity, whether or not the health practitioners involved are employees or agents of the sponsor of the activity or the provider of the services.

8.32 The College of Midwives raised a concern in relation to the protection of perinatal mortality review processes of District Health Boards. Many of the regulations specifically covering these as protected quality assurance activities define the activity as based on 'information derived from health practitioners who provide health services on behalf of the district health board'. Because some providers of maternity services are independent of the District Health Board, such a regulation may exclude them from this information. The issue here is not to do with the legislation but with the way that these regulations have been drafted when application was made for the activity to be declared protected. Some District Health Board applications specifically refer to information from practitioners who have access agreements with the District Health Boards and in that way they include independent practitioners working in the District Health Board premises.

**Recommendation 30:** That District Health Boards review their provisions for protected quality assurance activities and apply for any necessary amendment to the relevant regulation so that, where appropriate, the regulation covers information from all practitioners involved in the activity, whether or not these practitioners are employees or independent practitioners.

8.33 A number of submissions pointed to the need for some research into the use and value of the protected quality assurance provisions. No detailed analysis or research has been carried out but such research would be useful to help decide on the place that these activities have in the new developments under the Quality Improvement Committee.

**Recommendation 31:** That the Ministry of Health and the Quality Improvement Committee consider research into the value and use of protected quality assurance activities.

## Chapter 9: Other Issues for Consideration

- 9.1 This chapter addresses issues in each part of the Health Practitioners Competence Assurance Act 2003 that have not been covered in previous chapters.

### Part 1: Key provisions

#### Interpretation section

- 9.2 The term 'emergency' is not defined in the Act but is used in section 8 (practitioners may practise outside their scope of practice in an emergency) and section 9 (it is not an offence to perform a restricted activity in an emergency). A question has arisen recently as to whether a pandemic or similar ongoing situation would be considered an emergency for this purpose. In such situations there is likely to be a need for practitioners to work outside their normal scope of practice in order to provide necessary care. Some regulatory authorities in other countries are considering emergency registration procedures for these situations. Under the New Zealand legislation, however, the provisions in sections 8 and 9 relating to emergencies should be sufficient as long as 'emergency' is clearly defined to include situations such as pandemics.

**Recommendation 32:** That a definition is added to section 5 of the Health Practitioners Competence Assurance Act 2003 so that it is clear that the term 'emergency' includes prolonged emergencies such as a pandemic.

#### Sections 7, 8 and 9

- 9.3 Issues regarding section 7 (unregistered people claiming to be registered) and section 9 (restricted activities) have been covered in paragraphs 5.7 to 5.15. Generally section 8 (practitioners must not practise outside their scope of practice) appears to be working as intended. There were a few comments to the effect that there are no clear processes or penalties if a health practitioner is found to be working outside their scope of practice. According to section 100(1)(e) such conduct would be grounds for discipline under the Health Practitioners Disciplinary Tribunal with associated penalties.
- 9.4 Submissions, however, point out that such cases may not reach the threshold that a professional conduct committee would require for referral to a hearing by the tribunal. The original Bill as presented to Parliament in 2002 contained a provision for an offence of breaching section 8 and a fine not exceeding \$10,000 on summary conviction. This provision, however, was struck out on the Health Select Committee's recommendation after it was argued that such cases against a registered practitioner should be dealt with through disciplinary proceedings. If such matters are an issue for a particular profession, it may be that professional conduct committees should consider referral for hearing by the tribunal. Similar

consideration should be given to discipline of practitioners who practise without an annual practising certificate.

## Part 2: Scopes of practice and registration

- 9.5 Scopes of practice were considered in paragraphs 3.7 to 3.17 and 4.2 to 4.3. Accreditation of educational courses was considered in paragraphs 4.4 to 4.6. An issue has been raised that, although section 12 requires responsible authorities to accredit and monitor educational institutions, it does not explicitly provide for that accreditation to be revoked. One of the Act's transitional provisions, section 224(2), clarifies that during the transition to this Act there was the power to revoke accreditation. The review finds that such a power should continue under the new Act.

**Recommendation 33:** That section 12 of the Health Practitioners Competence Assurance Act 2003 is amended to clarify that responsible authorities have the power to revoke an educational institution's accreditation.

- 9.6 Section 15(2) of the Act specifically allows responsible authorities to treat overseas qualifications as equivalent to New Zealand qualifications. The section, however, applies only to overseas qualifications. It has been pointed out that there may be occasions where authorities wish to recognise New Zealand qualifications even though they have not been listed as prescribed qualifications for the purpose of section 12. For example, an authority may wish to recognise a New Zealand qualification that is no longer offered or, in the case of a newly registered profession, may wish to recognise a qualification from a New Zealand institution before such time as the authority has been able to accredit the institution.

**Recommendation 34:** That section 15 of the Health Practitioners Competence Assurance Act 2003 is amended to give responsible authorities the power when necessary to recognise New Zealand qualifications as equivalent to qualifications that have been prescribed under section 12.

- 9.7 A number of responsible authorities have raised concerns about the provisions for fitness to practise in section 16. In particular there is a concern that the standard for refusing registration set in section 16(h) is too high: an applicant may not be registered if the authority has reason to believe that the applicant may endanger the health or safety of members of the public. Some authorities point to examples where an applicant may be considered unfit even though it is difficult to establish danger to the public. Among the examples cited relate to dishonesty offences that have not resulted in formal disciplinary findings, or drug offences that have received diversion from the police rather than conviction.

- 9.8 This issue is similar to the one raised in a number of submissions to the Health Select Committee in 2003. These submissions asked that the provisions include a requirement that applicants meet a 'fit and proper person' test or that they be excluded if they are 'of unfit character'. Some authorities currently require applicants to provide certificates of good character – even though lack of evidence of good character is not, according to section 16, a reason for refusing registration.
- 9.9 Section 16(h) was added to the Bill during the committee stages in the House as a result of a Government Supplementary Order Paper. It seems clear that Parliament chose to emphasise public safety as the measure rather than other aspects of character or fitness to practise. Moreover, the fact that section 16 lists eight specific reasons for refusing registration signifies that it was not the intention to allow authorities to determine unfitness at a more generic level such as 'conduct reflecting adversely on fitness to practise'.

**Recommendation 35:** That the Ministry of Health works with responsible authorities to clarify the intention of section 16 of the Health Practitioners Competence Assurance Act 2003 when judging fitness for registration.

- 9.10 Section 17(4) allows an authority's Registrar to decline registration until the applicant pays unpaid fines or costs imposed by the Health Practitioners Disciplinary Tribunal. The review agrees that these provisions should also apply in respect of unpaid fines or costs imposed through disciplinary proceedings under the former laws that the Act replaced.

**Recommendation 36:** That section 17(4) of the Health Practitioners Competence Assurance Act 2003 is amended to include fines and costs imposed on practitioners by disciplinary findings under the relevant former legislation on professional registration.

- 9.11 Section 18 deals with re-registration following removal from the register by a finding of the Health Practitioners Disciplinary Tribunal. It states that an authority may not authorise reinstatement to the register unless the practitioner has met any conditions imposed on them. In their submissions, some responsible authorities propose that in such circumstances they should also be allowed to consider other information provided in respect of the application for re-registration – such as from a professional conduct committee that took the case to the tribunal. However, the review finds that once the practitioner has met the conditions imposed by the tribunal, that should be sufficient to allow restoration to the register.

- 9.12 Sections 21 and 22 of the Act deal with authorisations of a practitioner's scope of practice. As mentioned in paragraph 3.17, these authorisations can be helpful in increasing workforce flexibility. However, it seems that some legal interpretations of these provisions are that authorisations can only place a limit on an individual's scope and cannot add to the scope of practice. The review finds that it was the intention of the Act that a responsible authority may authorise a practitioner's scope of practice to either extend or restrict that practitioner's scope of practice.
- 9.13 Section 26(4) allows a Registrar to decline to issue an annual practising certificate where an applicant has outstanding fines or costs imposed by the Health Practitioners Disciplinary Tribunal. In their submissions, some responsible authorities have proposed widening this power to include other monies owing in relation to professional regulation. The review does not accept that such a power is warranted for payments that have not been the subject of a hearing.
- 9.14 Section 31 covers the issuing of interim practising certificates. Some authorities took the view that the section is ambiguous in regard to whether there can be repeated extensions of interim certificates. The section specifically states that any extension must not be longer than 12 months after the date when the interim certificate was originally issued. Thus interim certificates are only to be used for a maximum period of 12 months.

### **Part 3: Competence, fitness to practise and quality assurance**

- 9.15 Section 35 requires authorities to notify employers, the Accident Compensation Corporation, the Ministry of Health and the Health and Disability Commissioner whenever an authority has reason to believe that a practitioner may pose a risk of harm to the public. It also states that business partners may be notified as well. This section is intended to allow authorities to provide early warning of concerns. However, the review finds it is appropriate for the sake of natural justice that authorities carry out inquiries before notifying in order to be sure that there is in fact a risk of harm – otherwise there could be many inappropriate notifications.
- 9.16 Section 39 provides for interim suspension of a practitioner's practising certificate pending a competence review. Yet section 38, which lays out orders that can follow from a competence review, does not include the possibility of suspension. Some authorities have submitted that these two provisions are inconsistent. However, section 38(1)(b) allows an authority to impose conditions on a practitioner's scope of practice and it can use such conditions to place any limits on the practitioner's ability to practise until the competency deficit has been addressed. Moreover, section 43(1)(b) allows for suspension in the case of unsatisfactory results of a competence programme.
- 9.17 Some authorities find that the options for competence programmes under section 40(3) are too restrictive. They ask that authorities should be able to tailor them to fit individual circumstances. The review finds that the provisions of the section allow considerable freedom and that extension is not necessary.
- 9.18 Some authorities have suggested that the power under section 42 to require health practitioners to make clinical records available should be extended to

records held by others (for example hospitals) about the practitioner's clients. The review finds that in such circumstances authorisation from the clients involved should be obtained before the other provider releases records.

- 9.19 Sections 45 to 50 concern practitioners who may be unable to practise because of a mental or physical condition. They set out that a person who becomes aware of such a situation must notify the Registrar and that the Registrar must organise for the matter to be considered by the authority as soon as practicable. Authorities have submitted that these provisions should be altered so that they only apply to a practitioner who intends to continue to practise and in that way do not subject a practitioner who has no intention of practising to a full investigation. However, another way to deal with such a situation would be for the practitioner in question to voluntarily relinquish their practising certificate.
- 9.20 Section 48 sets out provisions for interim suspension of up to 20 working days with the possibility of a further 20-day extension in order to get a medical examination. Authorities have submitted that these timeframes are too tight and have asked that interim suspension continues until the authority has made a decision about fitness to practise. However, submissions to the Health Select Committee in 2003 made it clear that there was a balance to be struck here and that a longer timeframe would be unreasonable for practitioners.
- 9.21 The review received submissions that the provision in section 49 to order an examination by a medical practitioner should be extended to examination by another relevant health practitioner. The example given was an extension to allow for psychological testing. The review finds that such a change would in certain circumstances allow the authority to carry out the intention of this part of the Act more effectively, more quickly and at less cost.

**Recommendation 37:** That section 49 of the Health Practitioners Competence Assurance Act 2003 is amended to allow a responsible authority to require an examination by a medical practitioner or another appropriate health practitioner.

## **Part 4: Complaints and discipline**

- 9.22 Part 4 of the Act, which deals with complaints and disciplinary matters, is covered in Chapter 7.

## **Part 5: Appeals**

- 9.23 The provisions of Part 5 in respect of appeals are working as intended.

## **Part 6: Structures and administration**

- 9.24 Chapter 5 has covered the provisions about establishment and membership of authorities and the powers of the Minister of Health. Chapter 6 has covered

provisions about extending the Act to cover new groups of practitioners. Other aspects of Part 6 are working as intended.

## **Part 7: Miscellaneous provisions and schedules**

9.25 Part 7 is working as intended.

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# Appendix 1: Terms of Reference for the Review of the Health Practitioners Competence Assurance Act 2003

## Background

The Health Practitioners Competence Assurance Act 2003 (the Act) came into force on 18 September 2004.

Extensive consultation undertaken in 2000 highlighted that there is general acceptance of the need for regulation of health practitioners, where there is a risk of harm to the public. Therefore, the principal purpose of the Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions.

The consultation also showed that there is general agreement on the conceptual framework that underpins the Act, both in New Zealand and internationally. However, because some provisions in the Act were relatively new and untested the Health Select Committee, when examining the draft legislation, proposed that the operation of the Act be reviewed three years following its commencement.

Section 171 of the Act requires that:

As soon as practicable after the expiry of the period of three years beginning on the commencement of this section [18 September 2004], the Director-General of Health must:

- review the operation of this Act since the date of the commencement of this section; and
- consider whether any amendments to this Act are necessary or desirable; and
- report the findings of the Director-General of Health to the Minister.

As soon as practicable after receiving the report, the Minister must present a copy of that report to the House of Representatives.

This document sets out the process for the review including:

- scope
- data collection processes
- development of discussion document
- consultation, analysis and finalising recommendations
- date for the Director-General of Health to report to the Minister of Health.

## **The process for the review**

### **Scope**

The review will focus on the way in which the Act is being operationalised to achieve its intent to protect the public. The core principles underpinning the Act will not be reviewed.

The scope of the review will be refined following consultation on the draft Terms of Reference. Areas identified for review will be categorised (for example, the discipline process, governance arrangements, authority structures, ensuring stakeholder communication with authorities, workforce implications, etc).

### **Data collection and literature review**

Data to inform the review may be collected in the following ways:

- a survey (to identify concerns with the operation of the Act)
- face-to-face meetings
- focus groups
- information requests from relevant parties (eg, registration authorities, Health and Disability Commissioner, Health Practitioners Disciplinary Tribunal, district health boards, etc)
- international research.

The Ministry will undertake a literature review to identify current trends in health workforce regulation internationally.

The information attained from the data collection and literature review will form the basis for the development of a discussion document.

### **Consultation on discussion document**

A discussion document identifying problems and recommended solutions will be drafted based on the data collected.

The consultation period on the discussion document will run for two months. It is anticipated the discussion document will be released mid-2008.

### **Collecting feedback on discussion document**

Feedback on the discussion document may be collected in the following ways:

- written submissions
- meetings with organisations/oral submissions
- regional meetings, hui, fono.

**Feedback analysis**

The Ministry will analyse responses and prepare draft recommendations which will take into account feedback on the consultation document.

**Finalising recommendations**

The recommendations will be finalised in consultation with the Legislative Design Committee.

**Reporting to the Minister of Health**

The final report will be forwarded by the Director-General of Health to the Minister of Health by 31 December 2008.

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## Appendix 2: List of Submitters and Workshop Attendees

Abano Rehabilitation  
Accident Compensation Corporation  
Adventure Development Ltd  
Allied Health Forum, Counties Manukau DHB  
Allied Health, Canterbury DHB  
Ambulance New Zealand  
Ashburton & Rural Health, Canterbury DHB  
Aotearoa New Zealand Association of Social Workers  
Arthritis New Zealand  
Association of Salaried Medical Specialists  
Auckland DHB  
Australia & New Zealand Association of Social Workers  
Australian & New Zealand College of Anaesthetists  
Canterbury DHB  
Capital & Coast DHB, Mental Health Social Workers  
Capital & Coast DHB, Regional Mental Health Social Workers Network  
Cardiac Sonographer  
Careerforce  
Child Disability, Waitemata DHB  
Chiropractic Board  
CHLabs  
Christian Science Committee on Publication for New Zealand  
Clinical Dental Technician  
Clinical Psychologists Group, Otago DHB  
College of Nurses Aotearoa (NZ)  
Compass Health  
Council of Medical Colleges  
Counselling Psychologist  
Counselling Services Centre  
Counties Manukau DHB  
Dental Council of New Zealand  
Dental Technician  
Department of Psychology, University of Auckland  
DHB Psychology Leadership Council  
Dietitians Board  
District Health Boards New Zealand  
Drug and Alcohol Practitioners' Association Aotearoa-New Zealand  
Family Planning  
Federation of Women's Health Councils Aotearoa New Zealand  
Framework  
Geneva Health  
Harbour Health NZ  
Health and Disability Commissioner

Health Practitioner's Disciplinary Tribunal  
Health Professional Advisory Group, Specialist Mental Health Services, Canterbury DHB  
Health Regulatory Authorities Secretariat  
HealthCare of New Zealand  
Hey Optometry  
Hutt Valley DHB  
IHC  
Institute of Clinical Psychology  
Institute of Counselling Psychologists  
Joint Faculty of Intensive Care Medicine  
Just Law  
KaroConsulting  
Kidz First Child Development, Counties Manukau  
Litchfield Healthcare Associates  
Matua Raki  
Mauora Taranaki PHO  
Medical Laboratory Science and Medical Radiation Technologists Boards  
Medical Advisor, Wairarapa DHB  
Medical Council of New Zealand  
Medical Laboratory Science Board  
Medical Radiation Technologists Board  
Medical Sciences Secretariat  
Medico-Legal Counsel, Auckland DHB  
Mental Health Commission  
Mental Health Social Workers, Capital & Coast DHB  
Midwifery Council of New Zealand  
Ministry of Health  
Music Therapy New Zealand  
National Centre of Mental Health Research & Workforce Development  
National Heart Foundation Senior Fellow  
National Radiation Laboratory  
Nelson Marlborough DHB  
New Zealand Anaesthetic Technicians Society  
New Zealand Association of Counsellors  
New Zealand Association of Medical Herbalists  
New Zealand Association of Occupational Therapists  
New Zealand Association of Optometrists  
New Zealand Association of Orthodontists (Inc)  
New Zealand Association of Psychotherapists  
New Zealand Audiological Society  
New Zealand College of Clinical Psychologists  
New Zealand College of Midwives  
New Zealand College of Nurses Aotearoa  
New Zealand Defence Force  
New Zealand Dental Association  
New Zealand Dental Hygienists' Association  
New Zealand Dietetic Association

New Zealand Home Health Association  
New Zealand Institute of Rural Health  
New Zealand Institute of Dental Technologists  
New Zealand Institute of Medical Laboratory Science  
New Zealand Institute of Medical Radiation Technology Inc  
New Zealand Institute of Rural Health  
New Zealand Medical Association  
New Zealand Nurses Organisation  
New Zealand Private Physiotherapists Association  
New Zealand Psychological Society  
New Zealand Psychologists Board  
New Zealand Public Service Association  
New Zealand Register of Acupuncturists  
New Zealand Rural General Practice Network  
New Zealand Society of Anaesthetists  
New Zealand Society of Physiotherapists  
Northland DHB  
Nurses at Lakes DHB  
Nursing Council of New Zealand  
Nursing, Otago DHB  
Nutrition Services, Auckland City Hospital  
Occupational Therapists in Counties Manukau DHB  
Occupational Therapy Board of New Zealand  
Occupational Therapy, Hutt Hospital  
Oceania Group  
Optometrists and Dispensing Opticians Board  
Osteopathic Council of New Zealand  
Osteopathic Society of New Zealand  
Overseas Doctors Forum  
Palmerston North Women's Health Collective  
Pathways  
PHARMAC  
Pharmaceutical Society  
Pharmacy Council of New Zealand  
Pharmacy Defence Association  
Pharmacy Guild  
Pharmacy Industry Training Organisation  
Physiotherapy Board of New Zealand  
Physiotherapy Society  
Platform  
Podiatrists Board  
Positive Women Inc.  
Presbyterian Support Central  
Presbyterian Support Otago  
Primary Care Development, Counties Manukau DHB  
Problem Gambling Foundation of New Zealand  
Problem Gambling Foundation of New Zealand – Midland Region

Programme Manager, Mental Health, Counties Manukau DHB  
Psychology Department, University of Canterbury  
Psychology Reports Ltd  
Psychotherapists Board of Aotearoa New Zealand  
Regional Mental Health Social Workers Network, Capital & Coast DHB  
Rehabilitation, Older Persons and Allied Health, Hutt Valley DHB  
Royal Australasian College of Surgeons  
Royal Australian and New Zealand College of Obstetricians and Gynaecologists  
Royal Australian and New Zealand College of Psychiatrists  
Royal Australian and New Zealand College of Radiologists  
Royal New Zealand College of General Practitioners  
Royal New Zealand Foundation for the Blind  
Royal New Zealand Plunket Society (Inc)  
School of Health Science, Unitec New Zealand  
School of Pharmacy, University of Auckland  
Social Work Leaders Council, Waitemata DHB  
Social Workers Registration Board  
South Link Health  
Special Education, Ministry of Education  
Sports & Exercise Science New Zealand  
St Johns  
Taylor Centre, Auckland DHB  
Te Kupenga o Hoturoa PHO  
Te Pou  
Te Puawai Tapu Trust  
Te Whariki Tautoko Incorporated Society (Māori Counsellors)  
The University of Auckland  
The Werry Centre  
TRG Group Ltd  
Tuwharetoa Health Services  
Unitec New Zealand  
UNITEC NZ  
Unknown  
Visique Lowes & Partners  
Waikato District Health Board  
Waitemata DHB  
Wairarapa DHB  
Wellington Free Ambulance  
Wellington Independent Practitioners Association  
Wellington School of Medicine and Health Sciences  
Whangarei Hospital  
Women's Wellness Ltd

## **Appendix 3: Legislation Repealed by the Health Practitioners Competence Assurance Act 2003**

Chiropractors Act 1982

Dental Act 1988 (dentists, dental technicians, clinical dental technicians)

Dietitians Act 1950

Medical Auxiliaries Act 1966 (medical laboratory technologists, medical radiation technologists, podiatrists)

Medical Practitioners Act 1995

Nurses Act 1977 (included midwives)

Occupational Therapy Act 1949

Optometrists and Dispensing Opticians Act 1976

Pharmacy Act 1970

Physiotherapy Act 1949

Psychologists Act 1981

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## Appendix 4: Responsible Authorities Currently Established under the Health Practitioners Competence Assurance Act 2003

Profession	Responsible authority
Chiropractic	Chiropractic Board
Dentistry, dental hygiene, clinical dental technology, dental technology and dental therapy	Dental Council
Dietetics	Dietitians Board
Medical laboratory science	Medical Laboratory Science Board
Medical radiation technology	
Medicine	Medical Council
Midwifery	Midwifery Council
Nursing	Nursing Council
Occupational therapy	Occupational Therapy Board
Optometry and optical dispensing	Optometrists and Dispensing Opticians Board
Osteopathy	Osteopathic Council
Pharmacy	Pharmacy Council
Physiotherapy	Physiotherapy Board
Podiatry	Podiatrists Board
Psychology	Psychologists Board
Psychotherapy	Psychotherapists Board

## Appendix 5: Summary of the Way Responsible Authorities Assess Overseas-trained Practitioners under the Health Practitioners Competence Assurance Act 2003

Requirements of the Act	Ways to demonstrate requirements
Proof of identity	Passport, birth certificate. Verified documentation: marriage certification or proof of name change.
Able to 'communicate effectively' for the purposes of practising within the scope of practice	Examination. Referees' statements. Completing a cultural competency assessment or exercise. Sitting an online test. Taking part in an Objective Structured Clinical Examination that is designed to test openness to other cultures' approaches. Specific testing of awareness Māori cultural issues.
Able to communicate in and comprehend English, sufficient to protect the health and safety of the public	Sit an English language test.
Fit to practise – ie, has no investigations convictions, disciplinary matters or order from professional bodies or tribunals in New Zealand or overseas that may impact on fitness to practise	A certificate of good standing (CGS) usually relevant for last period or work but could be for last five years. The CGS should be no more than three–six months old. If via electronic exchange with an overseas regulator, the CGS will be current at the time of registration. The CGS is usually sent directly from the other jurisdiction. Police report not more than 3–6 months old. References – usually three recent ones. Self-declaration. Individual assessment by the board.
Has no mental or physical conditions that may mean the practitioner is unable to perform the functions required	Self-declaration. CGS.
Has the training, qualifications and experience to operate within the designated scope of practice	Offshore screening examinations. Review of curriculum vitae. Review of qualifications. Verification from source and/or a body that verifies information such as the Educational Commission for Foreign Medical Graduates. Review of references. Examination. Assessment. Recognition of the equivalence of qualification. Recognition of previous registration with a competent or comparable authority.

Source: Ineson S. 2008. *Issues Paper on International Best Practice in Health Workforce Regulation*. Wellington: Ministry of Health.

## **Appendix 6: Criteria for Activities Restricted under Section 9 of the Health Practitioners Competence Assurance Act 2003**

- There should be a clear risk of serious or permanent harm if the activity is done by anyone other than a health practitioner registered under the HPCAA.
- There should be no existing prohibitions/restrictions, such as those in the Crimes Act, Radiation Protection Act, Medicines Act.
- There should be strong grounds for believing there to be a likelihood of someone other than a registered health practitioner undertaking the activity, or having access to any necessary specialised equipment with which to do so.
- The activity should in principle be one capable of being “done to” a person. That is, activity that does not in itself involve contact with a person (such as the diagnosis of a condition or the selection of materials for a possible device) will not in itself necessarily pose a risk of serious or permanent harm.
- The wording should not inadvertently prohibit practitioners of a non-regulated, but established profession from carrying out activities that they are currently doing without risk of harm to the public.

Source: Ministry of Health. 2007. How was the list of restricted activities developed? URL: <http://www.moh.govt.nz/moh.nsf/indexmh/hpca-restricted-guidelines#list-development>. Accessed 22 October 2008.

# Appendix 7: New Professions under the Health Practitioners Competence Assurance Act 2003

## Criteria for assessing applications for inclusion in the Act

### Section 1 – Introduction

At the time of its enactment, the Health Practitioners Competence Assurance (HPCA) Act 2003 applied to 15 registration authorities. At the same time, the Act contained provisions enabling the scope of the Act to be extended to cover other practitioners and professions that provide health services. This document discusses these provisions and provides guidance to groups who might seek to apply for inclusion in the Act.

### Section 115 of the HPCA Act

Section 115 of the HPCA Act enables the Governor-General, on the advice of the Minister of Health, to designate health services of a particular kind as a health profession under the HPCA Act and to either:

- establish a registration authority to administer the registration of the profession; or
- provide that the designated profession be added to the profession or professions in respect of which an existing authority is appointed – thus creating a “blended authority”.

The HPCA Act does not provide for new or blended authorities to receive Crown funding. The set up and operational costs of the new authority will need to be borne by registrants. The financial viability of any proposed authority may have a bearing on the decision as to which of the section 115 options is the better mechanism. Applicants may be asked to provide comment on this issue.

### Section 2 – Purpose of Act paramount

Essentially, any application to come within the Act must show consistency with the purpose of the HPCA Act; the principal purpose of which 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* (s 3(1)).

Implicit in the Act is the protection of the public interest through ensuring that the public can readily find out what services a health practitioner is competent and entitled to provide. This will enable the public to know what health services can be expected from their chosen practitioner, and to know that that practitioner is competent and safe. The concept of providing the public with clear information on the nature of a profession, and the scope of practice and competencies of its practitioners, is reflected in the requirements set out below.

The development of these steps is also guided by the policy framework for regulating occupations. The framework (Cabinet Office Circular No (99) 6) includes that:

- intervention by the government in occupations should generally be used only when there is a problem or potential problem that is either unlikely to be solved in any other way or inefficient or ineffective to solve any other way
- the amount of intervention should be the minimum to solve the problem
- the benefits of intervening must exceed the costs.

The following process and evidence requirements under the HPCA Act help ensure compliance with this framework.

### Section 116 of the HPCA Act

Section 116 of the HPCA Act requires that, before recommending a health service be regulated as a health profession, the Minister be satisfied that the health services pose a risk of harm to the public or that it is in the public interest that the health service be regulated.

The Minister must also be satisfied that the providers of health services are generally agreed on the:

- qualifications for any class of providers of those health services
- standards that any class of service providers are expected to meet and
- competencies for scopes of practice for those health services.

Section 116 of the HPCA Act also requires that the Minister of Health consult with any organisation that, in the Minister's opinion, has an interest in the recommendations. The relevant text of section 116 is contained in the Appendix.

## Section 3 – Process for satisfying these requirements

### Evidence of need to regulate

Applications must establish the following elements:

- Application relates to the provision of a health service as defined by the HPCA Act.  
That is: "a service provided for the purpose of assessing, improving, protecting, or managing the physical or mental health of individuals or groups of individuals".
- The profession must be identifiable.
  - What is the nature of the activities undertaken by members of that profession?
  - How many practitioners are participating in the profession?
  - Are there any current professional organisations to which members of the profession belong or are eligible to join?
  - Does the public see the members of the profession as an identifiable group?

- Evidence provided by profession should state how the profession considers itself different from other professions which practice in similar areas (ie, identifying what the profession does that is not within the training and/or competence of another profession).
- There is evidence of need for regulation – provide evidence that goes to the purpose of the Act. Specifically, applications should identify:
  - the nature, frequency and severity of the potential risk to the public
  - the likelihood of the risk occurring
  - the nature, frequency and severity of the harm to, or the consequences for, the public
  - whether there are existing public safety concerns resulting from the activities of unregulated practitioners.

In addressing the risk of harm in this context you should endeavour to identify that risk associated with the practice of the proposed profession, as distinct from risks inherent in the area of health care within which the profession operates.

Where the focus of a proposal is more on the public interest than on the risk of harm, to accord with the principal purpose of the HPCA Act, there must also be some significant health-related aspect of the work of the putative profession in which it is appropriate to be seeking to protect the health and safety of members of the public.

Supporting evidence should identify if the profession is regulated overseas, and what risks (especially those to the public) have been identified in overseas experience or studies.

Provide a list of the organisations and individuals consulted on the regulation of this health service together with a summary of issues and concerns raised, agreements reached and any other matters.

### **Evidence of general agreement on qualifications, standards and competencies**

- Identify how the profession has been consulted on the application and what views were expressed [NB: the Ministry will then be able to use this information during the decision-making process as well as background for further discussions].
- Identify what sort of courses or training are currently offered for members of the profession.
- Identify what qualifications are generally held by members of the profession and the degree of uniformity in qualifications across members.
- List the agreed qualifications, standards and competencies expected of practitioners once regulated. [NB in assessing the list of qualifications expected of providers the Minister will be guided by the requirements in section 11 and 12 of the HPCA Act. These sections are contained in the Appendix to this Protocol].
- Provide evidence of how the qualifications, standards and competencies expected of practitioners reduces the public's risk of harm or helps achieve the public interest.

- Provide evidence of general agreement among the profession or representatives of the profession on the qualifications, standards and competencies expected of health practitioners of that profession.
- Identify the relationship between the generally agreed qualifications, standards and competencies of the profession proposed to be regulated, and the current scope(s) of practice of existing responsible registration authorities. Where possible this analysis should specify the similarities and differences in the qualifications, standards and competencies; at what educational level; whether at an accredited institution; whether continuing competency is a requirement of the profession (with details of the programmes and auditing processes).
- Identify if service providers (such as District Health Boards) and the New Zealand Quality Assurance/universities accord any standing or status to the profession and the qualifications.

### **New authority or addition of profession to existing authority?**

The starting premise when it comes to this decision is whether an existing authority agrees with the proposal or not and, if it does not, whether there is an overwhelming reason to override that authority.

To assist in this decision, applicants may be required to provide further information. That is, factors such as:

- estimated establishment costs
- estimated ongoing costs – including estimated compliance costs for service providers, employers and self-employed practitioners
- evidence that the benefits of regulation under the HPCA Act exceed the costs
- whether there are any similarities with scopes of practice, qualifications, training and competencies of other registered practitioners
- whether the proposed new profession works closely with or maintains close professional links with any current authority
- whether the proposed new profession wishes to establish a new authority or to form part of a current authority
- if it wishes to form part of a current authority, what the current authority thinks about the proposal and what expectations there are, if any, over representation of the proposed profession on the current authority
- if a blended authority is suggested, is a name change required.

### **Assessment and decision by Minister of Health**

The Ministry of Health will advise the Minister of Health on decisions to be taken on any applications received. This will require the Ministry to independently assess whether the public is at risk of harm or whether it would be in the interest of the public to regulate the health service.

This will involve:

- reviewing the evidence provided in the application (including undertaking separate investigation into overseas experience and evidence)
- consulting internally, drawing on available Ministry clinical expertise and if necessary, engaging independent clinical advisors to advise the Ministry
- consulting with any organisation that, in the Minister's opinion has an interest in the recommendations. This may include consulting with DHBs, registration authorities and individuals or organisations within the practitioner group.

If a decision is taken to recommend that the health services in the application be designated as a health profession, a separate decision will be required on whether to create a new authority or to add that profession to the ambit of an existing authority. The Ministry will:

- consider the information provided by the applicant on the establishment of a new authority or the joining with an existing authority
- if a blended authority is going to be considered, arrange a discussion between the Ministry, the new profession and the existing authority to talk through issues (including whether the proposed new profession should be represented on the authority)
- if agreement is reached, go ahead with the rest of the process
- if agreement is not reached, look at why not and see if any of those issues can be dealt with.

### **Appointment of authority and requirement to register**

The Minister will give effect to any decisions by recommending to the Governor-General an Order in Council. Any such Order in Council will prescribe the date that the decisions come into effect. It is likely that that date will take into account the time required to appoint authority members. The appointment process (which includes calling for nominations) can take some months.

The new authority (or any existing authority to which a profession has been added) will be required by the HPCA Act to gazette the necessary scopes of practice for that profession. Once that is done, practitioners undertaking the services described in the scopes of practice will be required to be registered with that authority.

# Appendix 8: Criteria for Assessing the Need for Statutory Regulation of Unregulated Health Occupations (Australian Government)

## Guiding principles

While it is acknowledged that occupational regulation may have a number of benefits, both for the occupation and for its individual practitioners, for the development of the criteria the following principles were adopted:

- the sole purpose of occupational regulation is to protect the public interest; and
- the purpose of regulation is not to protect the interests of health occupations.

Using these guiding principles six criteria were developed in the form of questions to address the issue of registration. Where appropriate, information to assist in addressing each criterion is also provided.

Note: It is considered that the occupation must meet all six criteria to be considered for registration.

## The criteria

### Criterion 1

It is appropriate for Health Ministers to exercise responsibility for regulating the occupation in question, or does the occupation more appropriately fall within the domain of another Ministry?

### Criterion 2

Do the activities of the occupation pose a significant risk of harm to the health and safety of the public?

The following should be considered when assessing whether there is significant risk of harm to the health and safety of the public:

- the nature and severity of the risk to the client group;
- the nature and severity of the risk to the wider public; and
- the nature and severity of the risk to the practitioner.

Areas which could be explored to identify a risk to public health and safety are:

- to what extent does the practice of the occupation involve the use of equipment, materials or processes which could cause a serious threat to public health and safety
- to what extent may the failure of a practitioner to practise in particular ways (that is, follow certain procedures, observe certain standards, or attend to certain matters), result in a serious threat to public health and safety
- are intrusive techniques used in the practice of the occupation, which can cause a serious, or life threatening danger

- to what extent are certain substances used in the practice of the occupation, with particular emphasis on pharmacological compounds, dangerous chemicals or radioactive substances
- is there significant potential for practitioners to cause damage to the environment or to cause substantial public health and safety risk.

Epidemiological or other data, (for example, coroners' cases, trend analysis, complaints), will be the basis for determining the demonstration of risk/harm.

### **Criterion 3**

Do existing regulatory or other mechanisms fail to address health and safety issues?

Once the particular health and safety issues have been identified, are they addressed through:

- other regulations, for example, risk due to skin penetration addressed via regulations governing skin penetration and/or the regulation of the use of certain equipment, or industrial awards;
- supervision by registered practitioners of a related occupation; and
- self regulation by the occupation.

### **Criterion 4**

Is regulation possible to implement for the occupation in question?

When considering whether regulation of the occupation is possible, the following need to be considered:

- is the occupation well defined
- does the occupation have a body of knowledge that can form the basis of its standards of practice
- is this body of knowledge, with the skills and abilities necessary to apply the knowledge, teachable and testable
- where applicable, have functional competencies been defined
- do the members of the occupation require core and government accredited qualification.

### **Criterion 5**

Is regulation practical to implement for the occupation in question?

When considering whether regulation of the occupation is practical the following should be considered:

- are self regulation and/or other alternatives to registration practical to implement in relation to the occupation in question

- does the occupational leadership tend to favour the public interest over occupation self-interest
- is there a likelihood that members of the occupation will be organised and seek compliance with regulation from their members
- are there sufficient numbers in the occupation and are those people willing to contribute to their costs of statutory regulation
- is there an issue of cost recovery in regulation
- do all Governments agree with the proposal for regulation.

### **Criterion 6**

Do the benefits to the public of regulation clearly outweigh the potential negative impact of such regulation?

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# Questions on the Proposed Recommendations of the Review of the Health Practitioners Competence Assurance Act

The Ministry of Health is interested in your views on the proposed recommendations of the final draft of the review report. The proposed recommendations are set out below.

1. Do you agree/disagree with the proposed recommendation?
2. Please provide reasons for your view.
3. If you disagree with the proposed recommendation, do you have any suggestions for alternate wording?

## Chapter 2: Overall conclusions

**Recommendation 1:** That it is noted that the Health Practitioners Competence Assurance Act 2003 is currently operating largely as intended, and that the Director-General of Health is instructed to carry out a further review of the Act starting in 2012 (page 11).

## Chapter 3: Communication and engagement for stakeholders

**Recommendation 2:** That responsible authorities and the Ministry of Health do more to inform the public about the Health Practitioners Competence Assurance Act 2003 through their websites, publications and other means – including making information about registered practitioners freely available (page 13).

**Recommendation 3:** That responsible authorities improve the processes around scopes of practice including developing a set of principles and guidelines, regular review, a central web-based point for notifying new consultations, and processes to allow any interested party to propose new or amended scopes (page 14).

**Recommendation 4:** That responsible authorities consult on and take account of the health services impact of their decisions and carefully weigh these up against considerations of public safety and, where appropriate and safe, they consider using the power they have under section 21 of the Act to authorise scopes of practice for individual practitioners (page 15).

**Recommendation 5:** That responsible authorities, mindful of the impact of practitioner fees on the health care system, try to restrain cost growth, look for ways to make efficiencies, minimise fee increases, and openly explain the basis for their fees and any increases (page 15).

## Chapter 4: Collaboration among responsible authorities

**Recommendation 6:** That responsible authorities work together and with Australian counterparts to identify and share best practice principles and arrangements for accreditation of educational institutions and programmes and that the Ministry of Health gives further policy consideration to developing a Trans-Tasman joint accreditation system for regulated professions (page 19).

**Recommendation 7:** That responsible authorities should collaborate with the Ministry of Health and Australian authorities to develop risk-based standards, processes and assessment models to be used for assessing overseas-trained practitioners (page 20).

**Recommendation 8:** That responsible authorities actively explore ways in which they can share with and learn from other authorities in order to improve quality and, where possible, reduce costs (page 25).

## Chapter 5: The Ministry of Health's role

**Recommendation 9:** That the Ministry of Health consults with responsible authorities and any other interested stakeholders about the processes for appointing members to responsible authorities and to the Health Practitioners Disciplinary Tribunal panel, and develops a set of criteria and competencies to help ensure the best appointments are made (page 31).

**Recommendation 10:** That section 120(4) of the Health Practitioners Competence Assurance Act 2003, which gives the power to have some members of responsible authorities elected, should remain unchanged and the question of whether to allow elections should continue to be considered on a case-by-case basis (page 34).

**Recommendation 11:** That the restricted activity concerning psychosocial interventions be revoked by Order in Council (page 36).

**Recommendation 12:** That the Ministry of Health arranges for a set of indicators to be developed in consultation with responsible authorities and other interested stakeholders to measure the effectiveness of the Health Practitioners Competence Assurance Act 2003 and to measure the performance of responsible authorities (page 37).

**Recommendation 13:** That the Ministry of Health consults with responsible authorities and other interested stakeholders to establish a standard template for authorities' annual reports and standard information to accompany notices of scopes of practice and fee changes (page 37).

**Recommendation 14:** That, as part of national workforce planning, the Ministry of Health works with responsible authorities and other stakeholders to improve the collection, collation, analysis and dissemination of comprehensive, accurate, comparable, timely and non-identifiable information about the registered health practitioner workforce and advises the Government as to whether any increase in resources or legislative change is required to make those improvements (page 38).

## Chapter 6: Extension of the Act to further groups of practitioners

**Recommendation 15:** That the Ministry of Health examines and consults on criteria for statutory regulation of unregulated health occupations with reference to criteria such as those proposed for Australia (page 42).

**Recommendation 16:** That section 114 of the Health Practitioners Competence Assurance Act 2003 is amended to give the Minister the power by Order in Council to join and restructure two or more existing authorities in situations where, after consultation, the Minister is satisfied that it is in the public interest to do so and that the authorities and their professions are generally in agreement (page 47).

**Recommendation 17:** That the Ministry of Health reviews the process for groups seeking to have a new health service regulated as a profession in order to gather full information with which to advise the Minister of Health as to whether statutory occupational regulation is recommended and, if so, what arrangements are best for appointing a responsible authority in respect of that profession (page 47).

**Recommendation 18:** That, after this report has been tabled in the House of Representatives, the Ministry of Health moves rapidly to make recommendations to the Minister of Health in respect of those groups for which it has already been decided that statutory regulation under the Health Practitioners Competence Assurance Act 2003 is appropriate (page 48).

## Chapter 7: Complaints and disciplinary matters

**Recommendation 19:** That sections 64 and 118 of the Health Practitioners Competence Assurance Act 2003 are amended to specifically recognise that it is a function of responsible authorities to receive complaints about the appropriateness of a practitioner's conduct and to protect complainants against civil or disciplinary proceedings unless they have acted in bad faith (page 50).

**Recommendation 20:** That section 68(2) of the Health Practitioners Competence Assurance Act 2003 is amended to give responsible authorities discretion whether to refer practitioners who have been convicted under an offence listed in section 67(b) to a professional conduct committee (page 51).

**Recommendation 21:** That sections 69 and 93 of the Health Practitioners Competence Assurance Act 2003 is amended to restrict interim suspension to situations where there are reasonable grounds to believe that a practitioner's conduct poses a risk of serious harm to the public (page 51).

**Recommendation 22:** That paragraph 17 of Schedule 3 to the Health Practitioners Competence Assurance Act 2003 is amended to allow the responsible authority to delegate any of its functions, duties or powers to a committee or to its Registrar (page 53).

**Recommendation 23:** That section 95 of the Health Practitioners Competence Assurance Act 2003 is amended to allow the Chair of the Health Practitioners Disciplinary Tribunal to issue, on his or her own, an order for non-publication of material in circumstance where all parties to a hearing consent to the non-publication order (page 54).

**Recommendation 24:** That section 102 of the Health Practitioners Competence Assurance Act 2003 is amended to enable the Health Practitioners Disciplinary Tribunal to set a minimum period before which a health practitioner whose registration has been cancelled cannot apply for re-registration (page 55).

**Recommendation 25:** That section 103 of the Health Practitioners Competence Assurance Act 2003 is amended to give the Health Practitioners Disciplinary Tribunal the power to instruct the appropriate executive officer of the Tribunal to notify any employer of orders of the Tribunal if the Tribunal is satisfied that such disclosure is in the public interest (page 55).

**Recommendation 26:** That section 6(5) of Schedule 1 of the Health Practitioners Competence Assurance Act 2003 is amended to bring it into line with the repeal of the Evidence Act 1908 and the enactment of the Evidence Act 2006 (page 56).

**Recommendation 27:** That section 104 of the Health Practitioners Competence Assurance Act 2003 is amended to clarify that responsible authorities are responsible for paying running costs of the Health Practitioners Disciplinary Tribunal, including costs not directly related to individual hearings and the costs of training tribunal panel members (page 57).

## Chapter 8: Protected quality assurance

**Recommendation 28:** That section 55(3)(a) of the Health Practitioners Competence Assurance Act 2003 is amended so that a person responsible for quality assurance activities is not required to be independent of the activity (page 62).

**Recommendation 29:** That section 58 of the Health Practitioners Competence Assurance Act 2003 is amended to simplify and reduce the administrative burden of the reporting requirements for quality assurance activities (page 63).

**Recommendation 30:** That District Health Boards review their provisions for protected quality assurance activities and apply for any necessary amendment to the relevant regulation so that, where appropriate, the regulation covers information from all practitioners involved in the activity, whether or not these practitioners are employees or independent practitioners (page 64).

**Recommendation 31:** That the Ministry of Health and the Quality Improvement Committee consider research into the value and use of protected quality assurance activities (page 64).

## Chapter 9: Other issues for consideration

**Recommendation 32:** That a definition is added to section 5 of the Health Practitioners Competence Assurance Act 2003 so that it is clear that the term 'emergency' includes prolonged emergencies such as a pandemic (page 65).

**Recommendation 33:** That section 12 of the Health Practitioners Competence Assurance Act 2003 is amended to clarify that responsible authorities have the power to revoke an educational institution's accreditation (page 66).

**Recommendation 34:** That section 15 of the Health Practitioners Competence Assurance Act 2003 is amended to give responsible authorities the power when necessary to recognise New Zealand qualifications as equivalent to qualifications that have been prescribed under section 12 (page 66).

**Recommendation 35:** That the Ministry of Health works with responsible authorities to clarify the intention of section 16 of the Health Practitioners Assurance Act 2003 when judging fitness for registration (page 67).

**Recommendation 36:** That section 17(4) of the Health Practitioners Competence Assurance Act 2003 is amended to include fines and costs imposed on practitioners by disciplinary findings under the relevant former legislation on professional registration (page 67).

**Recommendation 37:** That section 49 of the Health Practitioners Competence Assurance Act 2003 is amended to allow a responsible authority to require an examination by a medical practitioner or another appropriate health practitioner (page 69).