

**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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MANATŪ HAUORA

Foreword

The Health Practitioners Competence Assurance Act 2003 (the Act) came into force in September 2004. It brought all registered health professions in New Zealand, which had previously been regulated under their own separate statutes, under one consistent regulatory framework.

Section 171 requires the Director-General of Health to review the operation of the Act three years after it commenced, consider whether any amendments to the Act are necessary or desirable, and report the findings to the Minister of Health.

Since October 2007, the Ministry of Health has conducted the review in four phases including a survey of organisations and individual practitioners on the operation of the Act, a series of open workshops to develop proposals in April 2008, further workshops to discuss preliminary findings and recommendations in September 2008 and a draft report to the Minister was published for wider public consultation in January 2009. A wide range of responsible authorities, health service providers, professional bodies, unions, educators and consumer groups have participated in the workshops and made written submissions. These are listed in Appendix 2.

As required by section 171, this review has focused on the operation of the Act rather than its underlying policy settings. Overall, the review finds that the Act has been received positively by the sector and is operating as Parliament intended. There are, however, some areas where the Act requires clarification and I have recommended a number of minor legislative amendments to achieve that purpose. I have also recommended a further review of the Act's underlying policy settings in 2012.

The report highlights a number of operational changes that responsible authorities, the Ministry, district health boards and others can make without amending the Act. While I acknowledge that these recommendations may place an initial administrative burden on those agencies, they will ultimately improve the timeliness and efficiency of processes set up under the Act. They will also ensure that the Ministry receives comprehensive, accurate and comparable information that will improve planning for the future registered health practitioner workforce.

The review has been extensive and has involved many stakeholders to whom I am most grateful. It has culminated in a comprehensive report which will provide a useful reference for the sector and a platform for future analysis of the Act.

I have pleasure in delivering it.

Stephen McKernan
Director-General of Health

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Executive Summary

The Act's principal purpose 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 overall conclusion of the review is that the Act is operating largely as Parliament intended to achieve this purpose.

This view is also widely held among health sector stakeholders. In identifying evidence of success, it is often mentioned that health practitioners are now paying closer attention to competence and quality processes. There have also been improvements in the management of complaints and disciplinary processes.

There are, however, areas where the operation of the Act can be clarified and this report makes a number of recommendations for minor legislative amendments and operational changes. A full list of recommendations is set out in Appendix 1.

The recommendations can be summarised as follows:

- i. Better communication is needed about the Act and how responsible authorities operate. Four recommendations address effective communication between authorities, the public, funders, employers, practitioners, educators, policy-makers and other key stakeholders. (See Chapter 2.)
- ii. Three recommendations address the need for responsible authorities to continue to increase collaboration with each other in order to find the best ways of functioning and to reduce costs. (See Chapter 3.)
- iii. Six recommendations propose that the Ministry of Health should increase and improve its role as the Act's administering department. This would include improving appointment processes, reviewing the restricted activities and increasing oversight of the Act, including measures of responsible authority performance. The question of whether elections should play a part in appointing members to responsible authorities should continue to be considered on a case by case basis since opinion is still divided on that issue. (See Chapter 4.)
- iv. The process for considering when and whether health services should be designated as health professions can be improved and, in some cases, there may be a case for amalgamating authorities to make more efficient use of resources. Four recommendations propose changes in this area. (See Chapter 5.)
- v. The processes for managing complaints, operating professional conduct committees and the Health Practitioner Disciplinary Tribunal can be made more efficient by changes that introduce more flexibility. Nine legislative amendments are proposed for that purpose. (See Chapter 6.)
- vi. The provisions for designating quality assurance activities, protecting the confidentiality of information gathered and protecting practitioners from civil liability should be retained. Two legislative amendments and two operational changes are, however, proposed to allow these provisions to operate more effectively. (See Chapter 7.)
- vii. Five other legislative amendments and one operational change are proposed to improve other sections of the Act, along with one recommendation to ensure

authorities do not impose more restrictions on registering practitioners than are allowed under the Act. (See Chapter 8.)

Further review

As required by section 171, this review has focused solely on whether the Act is operating well to achieve the underlying policy settings for the Act. It has not reviewed the policy settings themselves. In truth, it would be difficult to assess the overall policy impact the Act has had on the sector just three years after it came into force, particularly when the Act introduced a number of significant changes.

It will be important to assess the effect the changes recommended by this review have on the sector and to consider the policy changes in health profession regulation that are developing in other jurisdictions. The review therefore recommends a further review of the policy settings, as well as the operation of the Act, in 2012.

Recommendation 1: That it be 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.

Chapter 1: Background

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

1.1 History of the Act

Prior to 2003 health professionals were mostly self-regulated by certification. That is, only those practitioners who met certain requirements were certified to use certain titles, and generally to 'hold themselves out' to be practitioners of a particular kind.

Judge Silvia Cartwright raised concerns about the governance, accountability and ethics of the medical profession in her Report on the Cervical Cancer Inquiry in 1988. This led to a new approach to regulation being taken under the Medical Practitioners Act 1995. A framework for reduced professional self-regulation was developed, with the Medical Council having an increased lay membership and a majority of appointed members. Discipline was managed by a separate disciplinary tribunal and doctors had protection for designated quality assurance activities.

When the Act was introduced in 2003, this framework was extended to 20 other regulated health professions and the Act replaced 11 earlier statutes (see Appendix 3).

1.2 International approaches

Most countries now regulate health practitioners by statute, but in doing so they take a variety of approaches and apply the regulations to a range of different professions. For example, new Australian legislation (due to be introduced from 2009) will regulate nine occupations. In the United Kingdom 35 professions are statutorily regulated. 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.

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 part of the state government.

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

The idea behind bringing all regulated health professions under one piece of legislation is to consistently achieve the principal purpose of protecting the health and safety of members of the public by providing mechanisms to ensure health practitioners are competent and fit to practise their professions. In doing so, the Act aims to balance ‘the demands of public safety against allowing practitioners sufficient involvement in the regulation of their profession’.¹

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. However, 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.

Authorities are established under the Act to be responsible for overseeing practitioners of a particular profession or professions (see Appendix 4). Each responsible authority must describe its profession(s) in terms of one or more scopes of practice, and 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, although scopes of practice may overlap between different professions. Authorities also 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 the practitioner is competent. These provisions are covered in Part 2 of the Act.

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.

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 in situations where a practitioner has been convicted of certain offences. A separate 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. The responsible authority for each profession is responsible for funding and supporting a Tribunal hearing against a member of that profession.

¹ Health Select Committee. 2003. *Health Practitioners Competence Assurance Bill (230-2) and Petition 2002/35 of Lesley Frederikson and 9000 others (16 May 2003)*. Wellington: New Zealand House of Representatives.

Part 5 provides for appeals to the District Court against the decisions of an authority and to the High Court for appeals against decisions of the Health Practitioners Disciplinary Tribunal.

Part 6 covers the responsible authorities: continuance of existing ones, establishment of new ones, and 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 5 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 the 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.

Part 7 contains miscellaneous provisions (including the requirement for this review), transitional provisions and consequential amendments.

Chapter 2: Communication and Engagement for Stakeholders

This chapter discusses the critical importance of good communication and engagement to the functioning of the Act. Most authorities are taking their responsibilities seriously, particularly in relation to their principal purpose of protecting public safety. There is, however, room for improvement in a number of areas. The chapter makes suggestions for how a number of agencies could improve their processes under the Act, but does not recommend any legislative changes.

2.1 Public awareness

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, in which case 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.

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, but only half list a district for each practitioner and only three include any more detailed information, such as business addresses. Business addresses clearly help the public when they are looking for practitioners. One authority mistakenly states on its website that it 'cannot give out personal details such as address's [sic] and telephone numbers for privacy reasons'.² While it would be inappropriate to list personal addresses, section 149(2) of the Act allows authorities the power to include business addresses unless the practitioner objects. The Privacy Act does not override section 149.

One of the explicit functions of the responsible authorities is 'to promote public awareness of the responsibilities of the authority'. Few authorities have been 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, and only some of these list publications for members of the public. Websites could easily include information to promote public awareness of the authority's responsibilities, and those authorities that have not yet done so could be encouraged to borrow ideas from those that have.

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. When the Act became law 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

² Midwifery Council of New Zealand. 2008. *How to Find a Midwife*. URL: <http://www.midwiferycouncil.org.nz/main/HowToFindAMidwife>. Accessed 22 November 2008.

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 business information about registered practitioners freely available.

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

The health workforce challenges facing New Zealand 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. Authorities that have developed new scopes of practice include the Nursing, Pharmacy and Medical Councils.

District Health Boards (DHBs) 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. The Nursing Council's development of the scopes of practice for nurse practitioner and nurse assistant encountered problems, and eventually resulted in the Government using powers under the Regulations (Disallowance) Act 1989 to amend the scope of practice. In light of this case, there were calls for a review of the policy that makes authorities responsible for setting scopes of practice and for making other decisions that affect the profession, and a suggestion that the Minister of Health have the power to intervene.

However, although the Regulations Review Committee in this case found that the Nursing Council's consultation process could have been improved, it also found that the Council had complied with the Act's requirements. Given that Parliament designed the Act to limit the Minister's powers, allowing the Minister to set scopes of practice would be a significant change. Similarly, the Act deliberately limits the power of employers, professions and professional organisations by the way authorities are structured, appointed and empowered, and a change to how authorities decide on scopes would materially affect this balance. While this case raises 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.

The Act requires that before specifying or amending a scope of practice, an authority must consult with its practitioners and any other organisations the authority considers will be affected by the proposal. Some practitioners and organisations are concerned that authorities are sometimes not consulting widely enough on 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 they are still relevant, and during those reviews the authority should ask for comment from interested parties. The frequency of the reviews will need to be determined by each authority, bearing in mind the size of its membership, feedback from the sector and cost implications.

Recommendation 3: That responsible authorities improve the processes relating to scopes of practice, including developing a set of principles and guidelines, regular review, a central web-based location for notifying new consultations, and processes to allow any party that is directly affected by changes to propose new or amended scopes.

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, DHBs think authorities have sometimes set unreasonably high requirements when accrediting overseas-trained practitioners. 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.

Although the Act gives authorities flexibility in relation to individual practitioners and their scopes of practice, some authorities appear to focus solely 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 to a practitioner's registration. Such conditions can constrain a practitioner's practice. Several authorities consider that individual scopes of practice are difficult to monitor and that workforce issues are not a relevant consideration. However, the purpose of the Act is to protect both the health and safety of members of the public. To protect public health, services must be fully resourced. The Ministry of Health intends to write to the registration authorities clarifying the options that are available for authorising individual scopes of practice.

Recommendation 4: That responsible authorities consult on and take account of the health service impact of their decisions and carefully weigh these against considerations of public safety and, where appropriate and safe, consider using the power they have under sections 15 and 22 of the Act to authorise scopes of practice for individual practitioners.

Another area of concern to DHBs and other employers is the increase in 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.

Authorities are required to publish fees in the *New Zealand 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. In 2007 the Committee reported on its examination of the fees set by the Midwifery Council³ and has also made 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.

2.3 Communication and engagement with practitioners and professional groups

The Act is based on a system in which responsible authorities make decisions about professions. To function effectively, authorities must maintain the confidence and respect of the professions for which they are responsible. This review finds that most – but not all – responsible authorities have the confidence of their professions. Some level of criticism is to be expected 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. However, ongoing tensions with significant parts of the profession(s) for which it is responsible make it difficult for the authority to adequately fulfil its functions.

³ Regulations Review Committee. 2007. *Complaint regarding the Midwifery (Fees) Notice 2005*. New Zealand House of Representatives.

Some professional organisations have argued that elections should be a part of the appointment process, to help ensure the members better represent the professional perspective. On the one hand, authorities as regulators do not represent the professions for which they are responsible – that is the role of the professional associations. On the other hand, it is important that all authorities establish and maintain the respect and confidence of 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. 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, and authorities generally take this responsibility seriously and consult carefully. Their potential impact means that authorities need to take particular care to explain their final decisions.

Authorities also have to decide on a number of other key matters, such as 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. 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, but practitioners and particular professional organisations also have a responsibility to take the initiative in communicating with their responsible authorities.

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.

Chapter 3: Collaboration among Responsible Authorities

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, therefore, if they did not also vary in their capabilities and performance. This chapter looks at the different functions authorities have and finds that significant gains could be made if authorities worked more closely together to define and follow best practice.

3.1 Prescribing scopes of practice and qualifications

Scopes of practice defined by responsible authorities rather than specified in legislation were a significant and controversial new concept in the Act. The aim was to support workforce flexibility so that health professionals match new service models and new technologies. To work as intended, scopes of practice should be open to regular review, as should the way scopes are defined. 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.

3.2 Accrediting and monitoring educational institutions and programmes

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

The changes to Australian health professional regulation that are currently being developed for introduction in 2009 include new national arrangements for accreditation. Initially accreditation functions will be assigned to existing agencies, but within 12 months they will 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 be managed by a single process.

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 the fact that only nine professions will initially be registered across all Australian states and New Zealand has different cultural competency standards. Some professions also have different qualifications requirements in Australia. As a result it may take some time to achieve a 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 the accreditation of educational institutions and programmes, and that the Ministry of Health give further policy consideration to developing a trans-Tasman joint accreditation system for regulated professions.

3.3 Practitioner registration (particularly for overseas-trained practitioners), issuing annual practising certificates and maintaining registers

Responsible authorities must determine policies for registering individuals and issuing annual practising certificates. For New Zealand-educated practitioners this 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.

The Act requires that applicants for registration 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.

On the one hand, DHBs, other employers and some overseas-trained practitioners have voiced concerns that standards are inconsistent and sometimes an unnecessary barrier to the entry of competent practitioners. Some even suggest that authorities are acting to protect the market position for existing practitioners by making entry difficult. 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.⁴ In some high-profile cases practitioners have been registered as a result of false documentation.

⁴ 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.

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). In this area, authorities could learn much from each other and from approaches in other jurisdictions. An agreed standard for 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 in Australia.

Recommendation 7: That responsible authorities 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.

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.

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.

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.

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.

The requirements for assessing maintenance of competence are covered from paragraph 3.5 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 2.1 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.

A further issue has been raised in relation to the term of annual practising certificates issued under the Act. Section 30(2) of the Act states that a practising certificate must be issued for a period no longer than one year from the date of issue. For most professions, a one-year term is appropriate. However, some professions do not have continuing professional developments and their authorities maintain that there is little reason for their members to show annual compliance. The decision to allow authorities a discretion to extend annual practising periods beyond one year raises important policy considerations which should be considered when the Act is next reviewed in 2012.

3.4 Reviewing and promoting competence

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 order that the practitioner undertake a competence programme, have a restriction on their practice, or sit an examination or assessment. Most authorities have developed similar processes for reviewing practitioner competence, involving on-site review of the practitioner's performance. There is the potential for authorities to generate a set of agreed principles and processes for reviews, which could be used as guidelines for all authorities and their practitioners.

3.5 Recertification programmes to ensure ongoing competence

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 by setting up recertification programmes under section 41 of the Act.

There is no internationally agreed best way to assess health practitioner competence, but 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.

Recertification processes are valuable, but they can never be foolproof. 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 also be aware that such programmes can add significant costs to the system and should work to match costs to the 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.

3.6 Managing practitioners unable to function for practice

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. 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, while 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.

As with 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.

3.7 Setting standards for clinical and cultural competence and ethical conduct

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. Some standards for clinical competence are specific to the profession, while others are 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.

Several submitters have queried whether the Act should be amended to include a reference to the Treaty of Waitangi. This would involve consideration of the Act's underlying policy settings which is planned for 2012.

Some submissions to this review claimed that standards (particularly ethical standards) are matters for a profession rather than the responsible authority to set. Others argued that responsible authorities should refer to professional organisations and best evidence in developing standards of clinical competence, whereas cultural and ethical standards should be left to outside experts.

The review finds that there is significant common ground among professions on all standards and that 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

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.

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. The newly established Psychotherapists Board is sharing office space and some secretarial services with the Occupational Therapy Board.

Authorities could share more of their administrative capabilities and functions rather than developing all 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. Sharing is not necessarily easy. For example, because changing IT systems is very expensive, it would take many years before any savings from sharing would 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.

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 this association and fund a small secretariat. Under the auspices of HRANZ there have been regular meetings, and authorities have completed a number of shared projects. HRANZ has considerable potential for much greater collaboration on issues of mutual interest. It is also a good vehicle for communication between authorities and stakeholders.

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.

Chapter 4: The Ministry of Health's Role

The Ministry of Health is the government department that administers the Act. This chapter identifies areas where the Ministry could 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. It makes recommendations for some extensions designed to help achieve the Act's purpose in full.

4.1 Enforcement of the Act

The Ministry of Health investigates and can bring about prosecutions for offences under nine sections of the Act and paragraphs 12 and 13 of Schedule 1. To date complaints, investigations and prosecutions have only involved sections 7 and 9 (and, on one occasion only, 172), so these will be examined in more detail.

Section 7: Unregistered people must not claim to be registered

Section 7 makes it an offence for an unregistered person to claim to be a registered health practitioner, but it does not stop those offering services (apart from a limited range of restricted activities). Some practitioners think this system is wrong because it does 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.

These provisions only work if the public understands the difference between a registered and an unregistered person. In Chapter 2 it was proposed that responsible authorities should take a more substantial role in promoting public awareness, and that the authorities and the Ministry of Health should be more active in informing the public about how the Act works.

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 may revisit this question in the next review.

Responsible authorities and professional bodies are concerned that the Ministry of Health has not brought more prosecutions for offences under section 7 (or 9) of the Act. A complaint about a possible breach of section 7 is investigated to see if there is evidence that the complaint is a serious one, such as 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.

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 avoids commencing prosecutions that are unlikely to succeed.

Section 9: Complaints about unregistered people practising restricted activities

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.

In these cases the Ministry of Health investigates the complaint and, if it finds there is evidence to substantiate the complaint, it seriously considers prosecution. Sometimes it can face difficulties bringing a prosecution because of the difficulty in getting sufficient evidence to prove the case and gain a conviction.

4.2 Appointments to responsible authorities

The size and make-up of authorities

Under section 120 the Minister of Health appoints between 5 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.

Some submissions called for a requirement that Māori be represented on each authority. A specific legislative requirement was considered unnecessary at the time the Act became law, and 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.⁵ The review finds no reason to recommend a change.

Membership must include two laypeople if the board has eight or fewer members and three laypeople if it has nine or more. In general, lay members are thought to have helped authorities function more effectively. A number of submissions sought to define 'layperson' so as to disbar various categories, including former health practitioners, lawyers and those currently associated with the health sector. 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, and 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.

⁵ Cabinet Office. 2002. *Government Appointments: Increasing diversity of board membership*. Wellington: Cabinet Office.

Under the Act the majority of the members of an authority must be health practitioners. Some submissions supported changing this provision to specify that the health practitioners be members of the profession(s) regulated by that authority. However, the provision that 'authorities will need sufficient members with clinical knowledge to adequately carry out their functions'⁶ 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. Where 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. The review can see no reason to require a legislative change to prevent such exceptions.

A few submissions voiced concerns that where authorities regulate more than one profession, the membership of the authority may not be appropriate to make good decisions for all its professions. Currently only two authorities regulate more than one profession,⁷ but in future regulation of multiple professions could become more common if new and sometimes small professions become regulated. However, any legislative requirement 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 relating to 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 so that it properly fulfils its functions.

Appointment procedures

The Act requires the Minister of Health to invite nominations for appointments to responsible authorities, and to consider all nominations before making appointments. The Ministry of Health manages this process. Once it receives nominations, the Ministry checks that the individuals are eligible, and then 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 on how well individual nominees might fill these gaps. The Ministry forwards the full list of eligible nominees, along with comments and recommendations, to the Minister. The Cabinet Office Circular, *Government Appointments: Increasing diversity of board membership* (2002) recommends that government bodies have a membership that reflects an appropriate gender, age, ethnic and geographical balance. Cabinet must approve the Minister's proposed appointments before they are finalised and published in the *New Zealand Gazette*.

⁶ Health Select Committee. 2003. *Health Practitioners Competence Assurance Bill (230-2) and Petition 2002/35 of Lesley Frederikson and 9000 others (16 May 2003)*. Wellington: New Zealand House of Representatives.

⁷ 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.

These appointment processes are relatively ad hoc and opaque, and various submissions call for improvements. In the United Kingdom some authorities have developed specific guidance about the skills looked for in members of the authority.⁸ The recent United Kingdom White Paper about health professional regulatory reform⁹ 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 consult 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 develop a set of criteria and competencies to help ensure the best appointments are made.

Section 87 of the Act requires the Minister to 'maintain a panel' of practitioners and laypersons to form the Health Practitioners Disciplinary Tribunal. Appointments are subject to the Minister's continued approval, which must be confirmed no less than five-yearly.

An issue has been raised with the term of appointment for panel members. It has been suggested that the Act should be amended to allow the Minister to appoint panel members for periods up to five years. This would allow appointments to be staggered. However, such an amendment would first require a review of the underlying policy setting for the duration of panel appointments. The review therefore finds that this issue should be considered in the 2012 review.

Elections to responsible authorities

Under previous legislation three out of the 11 professional regulatory authorities had some members elected by their respective professions.¹⁰ One of the aims of the Act was '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'.¹¹ However, section 120(4) includes the power to make regulations that provide for one or more of the health practitioner members to be practitioners elected in an election conducted by the authority.

⁸ General Chiropractic Council. 2007. *Code of Conduct for Members of the General Chiropractic Council*. London: General Chiropractic Council.

⁹ Secretary of State for Health. 2007. *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*. London: Stationery Office.

¹⁰ Dentistry, medicine and pharmacy.

¹¹ Health Select Committee. 2003. *Health Practitioners Competence Assurance Bill (230-2) and Petition 2002/35 of Lesley Frederikson and 9000 others (16 May 2003)*. New Zealand House of Representatives.

This power represents a compromise between the desire to have a consistent process (with ministerial appointments for all authorities) and the recognition that some professions are strongly of the view that elections should play some part in selecting the members of their responsible authority.

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. In 2006 the then Minister of Health asked the Ministry to consult on whether regulations should be made providing for election to the Medical Council. The arguments both for and against elections are largely the same as those voiced at the time 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 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. Instead, the question of whether to allow elections should continue to be considered on a case-by-case basis. In late 2008, the incoming government strengthened the election process by passing regulations for the Medical Council of New Zealand to hold elections for practitioner members. Similar regulations have since been agreed to for the Nursing Council of New Zealand. If Recommendation 9 is accepted and acted upon, so that the provisions for appointment processes are improved, it may be that the calls for elections will lessen.

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, remain unchanged and the question of whether to allow elections continue to be considered on a case-by-case basis.

4.3 Administering the list of restricted activities

The Minister of Health can, under section 9 of the Act, restrict certain activities to registered health practitioners when the Minister is satisfied there is a risk of serious or permanent harm from the activity. (See Appendix 6 for the current list of restricted activities.) In other words, 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.

The list of restricted activities in New Zealand was developed after consultation, as required under section 9(2). A set of criteria was developed to help decide when an activity should be restricted (see Appendix 6), and six activities were eventually adopted into regulation. The review heard a number of concerns about one of these, performing a psychosocial intervention with an expectation of treating a serious mental illness without the approval of a registered health practitioner'. Concerns centre on two points: the definition is unenforceable because the meaning of both 'psychosocial intervention' and 'serious mental illness' is too vague, and it is unreasonably restricting social workers and counsellors, who can safely perform such activities even though not registered under the Act. 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.

Some stakeholders expressed concern that removing the activity would enable unskilled practitioners to perform psycho-social interventions. However, the Code of Health and Disability Consumers' Rights applies to both registered and unregistered healthcare providers. If an unregistered provider holds him or herself out as having the skills of a skilled practitioner, he or she will be held to that standard.

Submissions also proposed adding a significant number of activities as new restricted activities (eg, fitting or supplying non-prescription contact lenses, providing care during childbirth). However, in some cases other laws already control the activities satisfactorily, and other cases lack clearly established evidence that there is a need to restrict the activity to protect the public safety.

The review finds that the provision to designate restricted activities is appropriate, and that, 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.

4.4 Oversight of the Act and the performance of responsible authorities

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 be considered. Gathering evidence of responsible authority performance is more straightforward, and some authorities are already considering such measures. The United Kingdom's Council for Health Care Regulatory Excellence has developed a system that could be adapted for New Zealand use.

Authorities are statutory bodies established under sections 114 and 155 of the Act. Section 117 provides that 'every authority appointed by or under this Act is a body corporate with perpetual succession, and has and may exercise all the rights, powers, and privileges, and may incur all the liabilities and obligations, of a natural person of full age and capacity'. Authorities are funded by the professions they regulate and are not subject to the Public Finance Act 1989.

As noted above, particularly in Chapter 2, 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. The Ministry of Health can play a number of useful roles here, including:

- explaining, and educating people about, the Act and the functions of authorities
- arranging, in consultation with authorities and sector stakeholders, for a set of indicators of best practice to be developed to measure authorities' effectiveness
- assisting in mediating an agreement between an authority and sector stakeholders¹²
- having a role if a Minister of Health chooses to use the power to audit an authority, which is provided in section 124 of the Act (that power has not yet been used).

Authorities are required to provide an annual report and to publish fees and scopes of practice in the *New Zealand Gazette*. Some authorities have not always fulfilled these requirements consistently, and the Ministry has a role to ensure they do so, as well as to advise the Minister of Health of any issues associated with any of the matters advised to Parliament.

In overseeing the Act, the Ministry 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 arrange 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 consult 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.

4.5 Statistical information

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 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'.

Responsible authorities hold important information about the health practitioner workforce and also collect detailed survey information 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 this data to analyse and publish their own workforce reports or make unidentifiable results available to the Ministry of Health, which analyses and publishes them. Governments, providers and professional

¹² It has already provided this form of assistance in a long-running dispute involving the Chiropractic Board and others.

organisations have increasingly accepted that workforce planning is essential to the future health system, and that comprehensive, accurate and timely workforce data is 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. 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 the required information.

Recommendation 14: That, as part of national workforce planning, the Ministry of Health work 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.

Chapter 5: Extension of the Act to Further Groups of Practitioners

This chapter looks at when and whether further health services should be designated as health professions for the purposes of the Act, and, if they are, how these professions should be regulated. Note that Recommendation 19 in this chapter requires legislative change.

5.1 The provisions of the Act

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.

Section 116 states 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. Section 116 also stipulates that the providers of the health services in question must be generally agreed on the qualifications for providers, standards expected and competencies for scopes of practice.

5.2 New services seeking to become regulated professions

A large number of occupational groups are seeking to become regulated, but concern over risk of harm to the public is often not the main driving force. Professions that are regulated under the Act see themselves, and are seen by others, as having a status as a health profession, and therefore legitimacy, which unregulated groups do not have. This situation may apply to the practitioners of a number of complementary and alternative health services.

The status of a profession can go further than merely how the profession is viewed by its members or others. For one thing, the Act has been referenced by other legislation and by employers and others in the health system. 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.¹³ The proposal would mean that patients of all practitioners recognised under the Act would be covered by the treatment injury provisions. 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 occupational

¹³ ACC. 2008. *Proposal to Move Treatment Provider and Registered Health Professional Definitions into Regulations; to Amend Existing Definitions and Add New Definitions; and to Amend the Accident Insurance ('Counsellor') Regulations 1999*. Wellington: ACC.

groups wish to be registered because in many cases employers such as DHBs require, and will pay or subsidise registration costs for, regulated health practitioners but not professions that are not regulated under the Act. This criterion can represent a significant financial incentive to seek recognition under the Act.

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.

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
- homoeopaths
- hypnotherapists
- medical herbalists
- natural health practitioners (homoeopathy, herbal medicine, naturopathy, remedial body therapy)
- radiation therapists
- social workers who work in health
- speech language therapists
- traditional Chinese medicine practitioners.

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.

Since 2004 the Ministry has consulted on whether there is a risk of harm to the public from, 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.

The Minister of Health has 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.

Recommendation 15: That, after this report has been tabled in the House of Representatives, the Ministry of Health move promptly to make recommendations to the Minister of Health in respect of those groups who have applied for statutory regulation under the Health Practitioners Competence Assurance Act 2003.

5.3 Criteria for regulating a new profession

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. 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 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.

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 scheme¹⁴ includes a useful set of principles and criteria for this purpose (see Appendix 8).

Recommendation 16: That the Ministry of Health examine and consult on criteria for statutory regulation of unregulated health occupations with reference to criteria such as those proposed for Australia.

Recommendation 17: That the Ministry of Health review the process for groups or existing authorities 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 on whether statutory occupational regulation is recommended and, if so, what arrangements are best for appointing a responsible authority in respect for that profession.

5.4 Expanding scopes of practice rather than designating new professions

Section 115 of the Act envisages that regulating an additional health service will involve designating it as a new health profession under the Act. An alternative approach is for the new service to become a scope of practice within an existing profession with which it has an affiliation. For example, 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.

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 a range of different natural healing therapies as scopes of practice under a single professional responsible authority.

5.5 Number and nature of responsible authorities

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.

¹⁴ Council of Australian Governments. 2008. *Intergovernmental Agreement for a National Registration and Accreditation Scheme for the Health Professions*. URL: <http://www.nhwt.gov.au/documents/National%20Registration%20and%20Accreditation/NATREG%20-%20Intergovernmental%20Agreement.pdf> Accessed 22 November 2008.

Cabinet approved the new authority but also asked this review to address the proliferation of registration authorities. New Zealand currently has 16 registration authorities which cover 21 health professions. This compares to only nine registration boards in Australia. The costs of setting up a separate authority each time a health service becomes designated as a health profession is a major concern, as is the potential rigidity that may be introduced into health service delivery if different health services are regulated by separate authorities. By over-regulating the health sector, the concern is that innovation will be stifled.

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 realised due to the number of responsible authorities and the lack of requirement for them to work together.’

Costs of regulation

Costs for responsible authorities are significant, and impose a cost on practitioners through registration fees and disciplinary levies. Such costs are part of doing business, and are passed on to the public and to employers. As such, they can affect fees or the cost of providing services.

The costs of running an authority 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. One study,¹⁵ based on financial information from most of the authorities, gives an indication of the main areas of expenditure and their relative size:

- secretariat costs 44%
- infrastructure 31%
- quality assurance costs 14%
- governance costs 11%.

This analysis shows that governance costs are only 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.

Another 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.

¹⁵ Information supplied by 12 responsible authorities, May 2008, and reported by: D Hyland. 2008. *Review of Financial Statements of Responsible Authorities*. Wellington: Ministry of Health.

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.

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

Stand-alone authority for new profession

The simplest, but probably the most expensive, option is to establish a new responsible authority for a new profession. This may be appropriate where the newly regulated profession is significantly different from all existing professions and where the number of likely registrants allows costs to be shared widely.

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

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, and some submissions suggest there are still ongoing tensions and issues between the Dental Council and some of its professions.

Although they may involve some difficulties, where practitioners or the services they provide are closely related there can be significant advantages to 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. Given the current and future mix of professions, it may make sense for more authorities to cover a number of similar professions.

This approach has been taken in other countries, and in New Zealand 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, homoeopathy 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.

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 be amended accordingly.

Recommendation 18: That section 114 of the Health Practitioners Competence Assurance Act 2003 be amended to give the Minister the power by Order in Council to join and restructure two or more existing authorities and/or add other practitioner groups to an existing authority in situations where, after consultation, the Minister is satisfied that it is in the public interest to do so and the authorities and their professions are generally in agreement.

Shared secretariats and infrastructure but separate governance boards

As mentioned above, 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 future become more common as particular authorities develop skills and systems that others wish to use.

Chapter 6: Complaints and Disciplinary Matters

This chapter looks at complaints and discipline, which are covered in Part 4 of the Act. The purpose of Part 4 is to 'provide consistent, co-ordinated, fair, and transparent processes for handling complaints against health practitioners'.¹⁶ The review finds that although the Act is generally interpreted consistently, a number of changes would increase the efficiency of the complaints system. Part 4 of the Act requires the most technical changes to ensure that it operates as Parliament intended.

6.1 Referral of complaints

Section 64 of the Act is designed to ensure that any complaint involving a consumer is dealt with consistently 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 assess the complaint to consider options for resolving it. 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.

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. The question has also 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 to 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 them. It would be appropriate, therefore, for 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 that has not affected a consumer. Likewise, it would be appropriate for Part 4 to accord to complainants who act in good faith protection against civil or disciplinary proceedings.

Recommendation 19: That sections 64 and 118 of the Health Practitioners Competence Assurance Act 2003 be 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.

¹⁶ Government of New Zealand. 2002. *Health Practitioners Competence Assurance Bill Government Bill 2002 No 230-1*.

Under section 65 of the Act, when an authority receives a complaint referred from the Health and Disability Commissioner it must assess the complaint promptly and decide what action to take. One possible action is to have the complaint considered by a professional conduct committee. Under section 67 authorities also receive notification from the courts when a health practitioner is convicted of 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.

Responsible authorities already have a number of options for dealing with complaints that raise questions about the appropriateness of a practitioner's conduct, and authorities have asked whether there could 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 be amended to give responsible authorities discretion over whether to refer practitioners who have been convicted under a minor offence listed in section 67(b) to a professional conduct committee.

6.2 Interim suspensions

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 have reasonable grounds for believing that the alleged conduct 'casts doubt on the appropriateness of the practitioner's conduct in his or her professional capacity'.

There are four other places in the Act referring to interim suspension: sections 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').

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 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, which is 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 be 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.

Some submissions asked that the phrase 'risk of serious harm' be amended to 'serious risk of harm'. The use of 'risk of serious harm' is restricted in the Act to occasions when interim suspension is under consideration. It is clear the intention was only to use this power to protect the public from significant harm. If the wording were 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.

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 serious risk of 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, mean that the public may be put at risk.

The counter view is 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. However, the Medical Council of New Zealand has noted that similar provisions already exist in relation to interim suspensions where there are concerns about a practitioner's health (section 48) or when a matter is being considered by the Health Practitioner's Disciplinary Tribunal (section 93).

The decision to alter the threshold for interim suspensions based on conduct raises important policy considerations which should be considered when the Act is next reviewed in 2012.

6.3 Professional conduct committees

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, although they are costly and time consuming and sometimes it takes a long time for a complaint to reach the committee concerned.

Section 71 stipulates that only the responsible authority can appoint the members of a professional conduct committee. This requirement has sometimes slowed the process of setting up a committee (eg, in the case of sudden illness of a committee member). Submissions have asked whether the committee appointments could be delegated to allow the authority's registrar to choose members, or to choose members from a panel 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, and 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 be amended to allow the responsible authority to delegate any of its functions, duties or powers to a committee.

6.4 Health Practitioners Disciplinary Tribunal

The Act established a tribunal, known as the Health Practitioners Disciplinary Tribunal, 'to hear those complaints against health practitioners that warrant significant disciplinary action'. 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 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 that the Tribunal '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'.¹⁷

Appointment of Health Practitioners Disciplinary Tribunal members and multi-professional cases

The review received a significant number of submissions about the need for a multidisciplinary tribunal that could consider a case where a multi-professional team is involved, even though 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. However, this would introduce the issue of the appropriate number and mix of lay and professional members, and could give rise to problems 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.

¹⁷ B Corkhill. 2007. *Submission to Ministry of Health for Purposes of Review of the Health Practitioners Disciplinary Competence Assurance Act 2003*. Wellington: Health Practitioners Disciplinary Tribunal.

Amendments concerning procedures of the Health Practitioners Disciplinary Tribunal

The chair of the Health Practitioners Disciplinary Tribunal, in his submission to this review, 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. There have already been a number of cases where the parties have invited the chair to make such orders by consent and it is appropriate for the Act to be amended to allow this practice.

Recommendation 23: That section 95 of the Health Practitioners Competence Assurance Act 2003 be 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 circumstances where all parties to a hearing consent to the non-publication order.

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) is only available if there is also an order for suspension of registration. The review agrees with the chair of the Health Practitioners Disciplinary Tribunal that this was not the intention of the legislation, and that section 101(1) should be clarified to ensure that penalties imposed by the Tribunal can be applied independently of whether or not other penalties have been applied.

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 Health Practitioners Disciplinary Tribunal notes that on several occasions the Tribunal has wished to set a minimum period within which a practitioner could not apply for re-registration, but the Tribunal has not had the power to set this condition. He notes that the Medical Practitioners Act 1995 allowed such a power. In support of setting such a minimum period, he 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'.

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, or because 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 be amended to enable the Health Practitioners Disciplinary Tribunal to set a minimum period within which a health practitioner whose registration has been cancelled cannot apply for re-registration.

The chair of the Health Practitioners Disciplinary Tribunal has asked that there 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, this may involve an unwarranted and unfair disclosure of information. 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 be 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.

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 be 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

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 the running of the Tribunal.

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 Health Practitioners Disciplinary Tribunal.¹⁸ In 2004 the authorities agreed a memorandum of understanding with the Tribunal establishing, 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.

¹⁸ The Chiropractic Board, the Dietitians Board and the Podiatrist Board.

When the Health Practitioners Disciplinary Tribunal was initially established its chair and the responsible authorities agreed that Tribunal members should receive training for their roles. In 2007 the chair of the Tribunal saw a need for further training for members because there were both new members and some who had experienced few or no hearings and needed renewal of training. Some authorities sought legal advice about whether funding 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 the use of their funds in this way.

However, it was the clear intention of Parliament that the responsible authorities would cover all of the costs of the Health Practitioners Disciplinary Tribunal (as had previously been the case: prior to the Act all of the professional bodies established and maintained their own professional disciplinary entities). There is also the potential for external funding to operate as a perverse incentive for the responsible authorities to use the Tribunal only as a backstop, or 'last resort' mechanism, with the primary responsibility for maintaining professional quality and standards residing with the responsible authorities.

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

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. 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 current arrangements.

It is worth reiterating 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 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 the authorities and the Health Practitioners Disciplinary Tribunal chair.

Chapter 7: Protected Quality Assurance

This chapter deals with sections 52 to 63 of the Act, 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.

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. However, submissions to this review have questioned aspects of the current provisions and this chapter recommends a number of legislative changes to improve their operation.

7.1 Background

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 (the Act) extended the arrangements to other health practitioners. The provisions in sections 52 to 63 of the Act provide a degree of qualified privilege to quality assurance activities.¹⁹ 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 and 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.

The quality assurance provisions of the Act differ in a number of ways to those in the Medical Practitioners Act 1995. The new provisions were the Bill's most contentious ones during its passage through the House. 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.

¹⁹ 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.

7.2 Overall findings

Most submissions to the review did not respond to the questions about quality assurance activities, and many workshop participants were unaware or had no experience of the quality assurance provisions in the Act. This 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.

Most of the submissions that addressed the quality assurance protections supported 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. However, most also noted that certain aspects of the provisions are difficult, unclear or unnecessary. These aspects are dealt with in more detail in the following sections.

A few submissions argued 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 DHBs 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.

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 the Act provides.

7.3 Investigation of serious adverse events

Section 53(2)(c) of the Act states that information is not protected as part of a quality assurance activity if the purpose is wholly or partly to prevent its disclosure in an investigation when the person has already been asked to respond to an investigation. From the history of the Bill and the nature of the debate at the time it is clear 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'.

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 the 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.

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 in which practitioners may engage in and learn from near misses and adverse treatment outcomes. The review does not recommend revisiting the current legislative provisions for 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.

7.4 Responsible persons

The Act requires that the Minister appoint a person to be responsible for each protected quality assurance activity. That person is responsible for reporting on 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. The sponsor nominates the responsible person when applying to have the Minister declare an activity as a quality assurance activity. The person must be independent of the health practitioners covered by the quality assurance activity.

The experience of a number of organisations, including DHBs, is that the requirement for independence from those involved with the activity can be difficult to meet, especially when the activity is managed outside the auspices of a hospital institution. The review finds that the concept of appointing an independent person to be responsible for each activity is useful and desirable, but that 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 be amended so that a person responsible for quality assurance activities is not required to be independent of those activities.

7.5 Reporting requirements

The person responsible for each quality assurance activity is required to supply a report on:

- 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.

The review heard that reports vary 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 resources to do more than provide a general report on the process.

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

7.6 Other issues

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. The submitters' questions concerned how to identify a responsible person in such cases and how to report on action the individual might take as a result of the activity.

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 the 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.

Another question raised is whether the provisions for exclusion of liability for quality assurance activities extends to people who are not registered practitioners (eg, social workers). 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'. 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.

The College of Midwives raised a concern in relation to the protection of perinatal mortality review processes of DHBs. 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 DHB, such a regulation may exclude them from this information. The issue here is not to do with the legislation but with the way these regulations have been drafted when application was made for the activity to be declared protected. Some DHB applications specifically refer to information from practitioners who have access agreements with the DHBs, and therefore include independent practitioners working in the DHB premises.

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

A number of submissions pointed to the need for 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 these activities have in the new developments under the Quality Improvement Committee. One submitter commented that protected quality assurance activities are sometimes used to assess competence and this is information that should be shared with authorities.

Recommendation 31: That the Ministry of Health and the Quality Improvement Committee consider research into the value and use of protected quality assurance activities, particularly instances where such activities have been used to identify competence concerns.

Chapter 8: Other Issues for Consideration

This chapter addresses issues in each part of the Act that have not been covered in previous chapters.

8.1 Part 1 – Key provisions

Interpretation section

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). The question has arisen 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 be added to section 5 of the Health Practitioners Competence Assurance Act 2003 so that it is clear that the term ‘emergency’ includes prolonged emergencies.

Sections 7, 8 and 9

Issues regarding section 7 (unregistered people claiming to be registered) and section 9 (restricted activities) have been covered in section 4.1. Section 8 (practitioners must not practise outside their scope of practice) appears to be generally working as intended. There were a few comments 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.

However, submissions have pointed out that such cases may not reach the threshold that a professional conduct committee would require for referral to a hearing by the Health Practitioners Disciplinary Tribunal. If this is 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 the discipline of practitioners who practise without an annual practising certificate.

8.2 Part 2 – Scopes of practice and registration

It has been pointed out 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 be amended to clarify that responsible authorities have the power to revoke an educational institution's accreditation after consulting with any party that is directly affected by changes.

Section 15(2) of the Act specifically allows responsible authorities to treat overseas qualifications as equivalent to New Zealand qualifications. The section applies only to overseas qualifications, and it has been pointed out that there may be occasions where authorities may 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 the authority has been able to accredit the institution.

Recommendation 34: That section 15 of the Health Practitioners Competence Assurance Act 2003 be 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.

A number of responsible authorities have raised concerns about the provisions for fitness to practise in section 16. In particular there is 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. The examples cited include dishonesty offences that have not resulted in formal disciplinary findings, or drug offences that have received diversion from the police rather than conviction.

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 a practitioner 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.

Section 16(h) was added to the Bill during the committee stages in the House as a result of a Government Supplementary Order Paper, and it seems clear that Parliament chose to emphasise public health and 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’. Accordingly, the Act itself does not require amendment, but the Ministry of Health will work with authorities to clarify any interpretation issues.

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

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 the Act replaced.

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

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 proposed that in such circumstances they should also be allowed to consider other information provided in 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, this should be sufficient to allow restoration to the register.

Sections 21 and 22 of the Act deal with authorisations of a practitioner’s scope of practice. As mentioned in section 2.2, 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.

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.

Section 31 covers the issuing of interim practising certificates. Some authorities took the view that the section is ambiguous as 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 the interim certificate was originally issued. Thus interim certificates are only to be used for a maximum period of 12 months.

8.3 Part 3 – Competence, fitness to practise and quality assurance

Section 35 requires authorities to notify employers, ACC, 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 there is in fact a risk of harm, otherwise there could be many inappropriate notifications.

Section 39 provides for interim suspension of a practitioner's practising certificate pending a competence review, but 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. Also, section 43(1)(b) allows for suspension in the case of unsatisfactory results of a competence programme.

Some authorities find that the options for competence programmes under section 40(3) are too restrictive and ask that authorities 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.

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 (eg, 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.

Sections 45 to 50 concern practitioners who may be unable to practise because of a mental or physical condition. They state that a person who becomes aware of such a situation must notify the registrar and the registrar must organise for the matter to be considered by the authority as soon as practicable. Authorities have argued that these provisions should be altered so that they apply only to a practitioner who intends to continue to practise, and so 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.

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 feel that these timeframes are too tight and have asked that interim suspension continue 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.

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 be amended to allow a responsible authority to require an examination by a medical practitioner or another appropriate health practitioner.

8.4 Part 4 – Complaints and discipline

Part 4 of the Act, which deals with complaints and disciplinary matters, is covered in Chapter 6.

8.5 Part 5 – Appeals

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

8.6 Part 6 – Structures and administration

Chapter 4 has covered the provisions about establishment and membership of authorities and the powers of the Minister of Health. Chapter 5 has covered provisions about extending the Act to cover new groups of practitioners. Other aspects of Part 6 are working as intended.

8.7 Part 7 – Miscellaneous provisions and schedules

Part 7 is working as intended.

Appendix 1: List of Recommendations

Note: Those recommendations that require legislative change are shaded.

Recommendation 1: That it be 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.

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 business information about registered practitioners freely available.

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

Recommendation 4: That responsible authorities consult on and take account of the health service impact of their decisions and carefully weigh these against considerations of public safety and, where appropriate and safe, consider using the power they have under sections 15 and 22 of the Act to authorise scopes of practice for individual practitioners.

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.

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 give further policy consideration to developing a trans-Tasman joint accreditation system for regulated professions.

Recommendation 7: That responsible authorities 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.

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.

Recommendation 9: That the Ministry of Health consult 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 develop a set of criteria and competencies to help ensure the best appointments are made.

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, remain unchanged and the question of whether to allow elections continue to be considered on a case-by-case basis.

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

Recommendation 12: That the Ministry of Health arrange 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 consult 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.

Recommendation 14: That, as part of national workforce planning, the Ministry of Health work 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.

Recommendation 15: That, after this report has been tabled in the House of Representatives, the Ministry of Health move promptly to make recommendations to the Minister of Health in respect of those groups who have applied for statutory regulation under the Health Practitioners Competence Assurance Act 2003.

Recommendation 16: That the Ministry of Health examine and consult on criteria for the statutory regulation of unregulated health occupations with reference to criteria such as those proposed for Australia.

Recommendation 17: That the Ministry of Health review the process for groups or existing authorities 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 on whether statutory occupational regulation is recommended and, if so, what arrangements are best for appointing a responsible authority in respect for that profession.

Recommendation 18: That section 114 of the Health Practitioners Competence Assurance Act 2003 be amended to give the Minister the power by Order in Council to join and restructure two or more existing authorities and/or add other practitioner groups to an existing authority in situations where, after consultation, the Minister is satisfied that it is in the public interest to do so and the authorities and their professions are generally in agreement.

Recommendation 19: That sections 64 and 118 of the Health Practitioners Competence Assurance Act 2003 be 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.

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

Recommendation 21: That sections 69 and 93 of the Health Practitioners Competence Assurance Act 2003 be 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.

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

Recommendation 23: That section 95 of the Health Practitioners Competence Assurance Act 2003 be 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 circumstances where all parties to a hearing consent to the non-publication order.

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

Recommendation 25: That section 103 of the Health Practitioners Competence Assurance Act 2003 be 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.

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

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

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

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

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 an activity, whether or not these practitioners are employees or independent practitioners.

Recommendation 31: That the Ministry of Health and the Quality Improvement Committee consider research into the value and use of protected quality assurance activities, particularly instances where such activities have been used to identify competence concerns.

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

Recommendation 33: That section 12 of the Health Practitioners Competence Assurance Act 2003 be amended to clarify that responsible authorities have the power to revoke an educational institution's accreditation after consulting with any party that is directly affected by changes.

Recommendation 34: That section 15 of the Health Practitioners Competence Assurance Act 2003 be 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.

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

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

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

Appendix 2: List of Submitters and Workshop Attendees

Abano Rehabilitation, Abano Health Group Ltd
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, Community Support Service ITO Ltd (Canterbury Health Laboratories)
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 National Office
Federation of Women's Health Councils Aotearoa New Zealand
Framework Trust
Geneva Health International
Harbour Health NZ
Hauora Taranaki PHO
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
Hutt Valley DHB
IHC New Zealand Inc
Institute of Clinical Psychology
Institute of Counselling Psychologists
Joint Faculty of Intensive Care Medicine
Just Law, Kerikeri
Karo Consulting
Kidz First Child Development, Counties Manukau
Litchfield Healthcare Associates
Matua Raki (National Addiction Treatment Workforce Development Programme)
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 Acupuncture Standards Authority
 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 Chinese Medicine and Acupuncture Society Inc
 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
 New Zealand Speech-language Therapists' Association
 Northland DHB
 Nurses at Lakes DHB
 Nursing Council of New Zealand
 Nursing, Otago DHB and Allied Health
 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 Health Ltd
 PHARMAC (the Pharmaceutical Management Agency of New Zealand)
 Pharmaceutical Society
 Pharmacy Council of New Zealand
 Pharmacy Defence Association
 Pharmacy Guild of New Zealand Inc
 Pharmacy Industry Training Organisation
 Physiotherapy Board of New Zealand
 Physiotherapy Society
 Platform Inc
 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 John New Zealand
Taylor Centre, Auckland DHB
Te Kupenga o Hoturoa PHO
Te Pou (The National Centre of Mental Health
Research, Information and Workforce
Development)
Te Puawai Tapu Trust
Te Whariki Tautoko Incorporated Society (Māori
Counsellors)
The University of Auckland
The Werry Centre for Child and Adolescent
Health

TRG Group Ltd
Tuwharetoa Health Services
Unitec New Zealand
UNITEC NZ
Unknown
Visique Lowes & Partners
Waikato DHB
Waitemata DHB
Wairarapa DHB
Wellington Free Ambulance
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

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	Medical Radiation Technologists Board
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

Shading denotes areas where improvements are recommended in this review.

Requirements of the Act	Ways to demonstrate requirements
Proof of identity	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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 of Māori cultural issues.
Able to communicate in and comprehend English, sufficient to protect the health and safety of the public	<ul style="list-style-type: none"> • 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)	<ul style="list-style-type: none"> • 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 to 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 to 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	<ul style="list-style-type: none"> • Self-declaration. • CGS.
Has the training, qualifications and experience to operate within the designated scope of practice	<ul style="list-style-type: none"> • 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: S Ineson. 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 Act.
- 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.*

The current restricted 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.

* 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 Act 2003 (the Act) 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 Act

Section 115 of the 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 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 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 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 Act help ensure compliance with this framework.

Section 116 of the Act

Section 116 of the 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
- competencies for scopes of practice for those health services.

Section 116 of the 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.²⁰

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 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?

²⁰ This refers to the appendix in the original protocol.

- 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 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 sections 11 and 12 of the Act. These sections are contained in the Appendix to this Protocol.)
- Provide evidence of how the qualifications, standards and competencies expected of practitioners reduce the public's risk of harm or help 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 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 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
- 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
- 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 practise 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 practise 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
- 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?