

# Regulatory Impact Statement

## 2012 Review of the Health Practitioners Competence Assurance Act 2003

### Agency disclosure statement

This Regulatory Impact Statement (Statement) has been prepared by the Ministry of Health. It incorporates input from public consultation on a review of the Health Practitioners Competence Assurance Act 2003 (the Act) and a series of focus groups held with key stakeholders. The Treasury, Ministry of Business, Innovation and Employment, State Services Commission, Accident Compensation Corporation, Ministry of Justice and the Health and Disability Commissioner were also consulted in the development of the paper to Cabinet Social Policy Committee associated with this Statement.

The 2012 review of the Act considered the strategic principles underlying the Act. Public consultation and focus groups identified five areas in which the Act could be enhanced.

The analysis in this Regulatory Impact Statement was constrained by a lack of information about the scope and terms of reference of five-yearly performance reviews of responsible authorities. The design of the performance reviews, the indicators selected and the performance review process will be subject to consultation with the sector. This lack of information about the scope and terms of reference for the five-yearly performance reviews has also impacted on an analysis of the associated costs.

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## Executive Summary

1. In 2009, Cabinet agreed that a strategic review of the Health Practitioners Competence Assurance Act 2003 (the Act) should begin in 2012. The purpose of the review was to consider the strategic principles underlying the Act and how the Act might be enhanced to better reflect the needs of New Zealand's health system and the role of its practitioners and responsible authorities.
2. The review indicated that the Act is generally working well, but identified five areas where enhancements could be made to update and improve its operation. The review included a public consultation process and focus group meetings with key sector stakeholders, including but not limited to the responsible authorities, the Health and Disability Commissioner and health professional organisations.
3. The principal purpose of the Act is "to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions." Under the Act, responsible authorities are established. Each responsible authority is charged with registering and issuing practising certificates, and determining the qualifications, competencies, fitness to practise and conduct standards a practitioner must meet to be registered and receive a practising certificate. Responsible authorities may appoint professional conduct committees (PCCs) to investigate complaints against registered health practitioners.
4. The review identified five areas in which the Act could be enhanced. Each area related to the role and functions of responsible authorities. The five areas identified were to:
  - (i) provide an assurance to the public and the Crown that the responsible authorities are carrying out their functions as intended, are focused on the principal purpose of the Act and are not at risk of regulatory capture
  - (ii) improve transparency about disciplinary proceedings relating to practitioners
  - (iii) provide greater recognition of the importance of team work and team communications across multi-disciplinary health practitioners
  - (iv) include the principles of transparency, integrated care, workforce flexibility and workforce planning
  - (v) improve workforce data collection on which to base health workforce planning.
5. The public consultation and, in particular, the focus groups considered options to address these five areas for improvement. This consultation process concluded with five recommendations, all of which reflect the strategic direction of the health system, including but not limited to quality and safety, improving public confidence, patient-centred care, multi-disciplinary teams, transparency, collaboration and consistency, and workforce planning.
6. The first recommendation is to require five-yearly performance reviews that provide the Crown and the public assurance that responsible authorities are carrying out their functions in the interests of public safety, and that the overall performance of each responsible authority is conducive to high public confidence in the regulatory system. Review terms of reference should be developed by the Ministry of Health in consultation with the responsible authorities.
7. The second recommendation is to require responsible authorities to make publicly available information about the basis on which they decided the outcome of complaints against registered practitioners, and to develop appropriate naming policies. This approach is consistent with protocols followed by the Health Practitioners Disciplinary Tribunal, the Health and Disability Commissioner and overseas health practitioner regulatory authorities.
8. The third recommendation is to require responsible authorities to set out standards for skills and practices that contribute to integrated health care, including standards for team work

and inter-professional communications across regulated and unregulated health professionals involved in a patient's care.

9. The fourth recommendation is to include a statement in the Act, and aligned to the purpose of the Act, that responsible authorities have regard to the principles of transparency, integrated patient-centred care, workforce flexibility and workforce planning.
10. The fifth recommendation is to amend the Act to require responsible authorities to collect robust workforce data from health practitioners and provide this to the Ministry of Health. This would facilitate planning for addressing workforce development needs and enable detailed workforce forecasts with a view to ensuring New Zealand has the health workforce required to meet future health needs.

### **Overview - Status Quo and problem definition**

11. The Act regulates certain health professions. Its 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." Under the Act, responsible authorities are established and charged with registering and issuing annual practising certificates to suitably qualified health professionals who meet competence, conduct and fitness requirements.
12. Each responsible authority is required to set up a professional conduct committee (PCC) to investigate complaints against individual health practitioners. The Act also establishes a separate Health Practitioners Disciplinary Tribunal to hear and determine charges against practitioners, which may be brought by a PCC or by the Health and Disability Commissioner's Director of Proceedings.

### *Requirement to review the operation of the Act*

13. Section 171 of the Act required the Director-General of Health (Director-General) to review the operation of the Act three years after it commenced in September 2004. The review took place between 2007 and 2009. Following the review, a Health Practitioners Competence Assurance Amendment Bill was drafted to give effect to recommendations from the operational review. Changes were largely of a minor or machinery nature and did not substantially alter the regulatory impact of the Act.
14. A recommendation was also made that the Director-General carry out a second, strategic, review of the Act, beginning in 2012. The 2012 review was intended to examine the underlying policy settings of the Act, which by 2012 would be approaching ten years in operation. The Bill from the 2007 to 2009 review was expected to be introduced in 2012, but was held over pending the outcome of the more substantive 2012 review.
15. The scope of the strategic review was agreed by Cabinet in July 2012 [CAB Min (12) 25/6]. The review was to assess how:
  - (i) the Act supports the delivery of the workforce required, both now and in the future
  - (ii) the pastoral care for the health and welfare of health professionals, to support the sustainability of the workforce, can be improved
  - (iii) a robust data collection system to inform sector intelligence and planning can be developed
  - (iv) the Act can work effectively within the wider health environment, and whether the purpose of the Act remains fit for purpose
  - (v) the health occupational regulatory settings can be improved
  - (vi) the Act can provide optimal levels and types of regulation for the next five to ten years
  - (vii) the operational functioning of the Act can be improved.

16. The strategic review of the Act began in 2012 with a consultation document covering a wide range of issues. The general conclusion from the consultation was that the Act is working well but from this, and subsequent focus group meetings, five key areas were identified where legislative change could enhance the Act. The five areas all related to the role and functions of the responsible authorities and were to:
- (i) provide an assurance to the public and the Crown that the responsible authorities are carrying out their functions as intended, focused on the principal purpose of the Act and are not at risk of regulatory capture
  - (ii) improve transparency about disciplinary proceedings relating to practitioners
  - (iii) provide greater recognition of the importance of team work and team communications across multi-disciplinary health practitioners
  - (iv) enshrine the principles of transparency, integrated care, workforce flexibility and workforce planning
  - (v) improve workforce data collection on which to base health workforce planning.
17. These areas all link with the strategic direction of the health system, including but not limited to quality and safety, improving public confidence, patient-centred care, multi-disciplinary teams, transparency, collaboration and consistency, and workforce sustainability.

## **Objectives**

18. The Health Practitioners Competence Assurance Act 2003 (the Act) and the Health and Disability Commissioner Act 1994 recognise the trust and confidence patients place in health professionals, and their relative vulnerability in the hands of unsafe health practitioners.
19. The recommended changes to the Act recognise this relationship of trust, and the need for responsible authorities and their registered health practitioners to not only act with integrity and in the interests of the public, but to be perceived to be doing so. The key objectives of the recommended changes are to provide tangible evidence of responsible authorities' performance of their functions and to increase the public perception of responsible authorities' performance.

## **Analysis**

20. Each of the five areas in which the Act could be enhanced, the options for addressing each area and the preferred option are set out in the following sections of this Statement.

### **(i) Provide an assurance that responsible authorities are focused on the principal purpose of the Act**

#### *Status Quo*

21. The Act requires each responsible authority to provide an annual report on the "operation of the authority during that financial year". The annual report must include financial statements for that year. Each annual report must be tabled in Parliament. Aside from these requirements, each responsible authority is able to decide the content of its annual report.
22. Under Section 124 of the Act, the Minister is able to appoint an auditor to audit the records of a responsible authority "for the purpose of ascertaining whether an authority is complying or has complied, with the provisions of the Act". The audit is not limited to financial performance. Under section 125 of the Act, the Minister may require a responsible authority to respond to concerns following an audit. This provision is intended to investigate a single authority with a performance issue rather than create assurance about the regulatory system as a whole.

### *Problem definition*

23. It is not possible within the current settings of the Act for the Crown to assert with confidence that responsible authorities are carrying out their functions as intended, and are regulating to improve public safety. The Act does not currently provide a mechanism to address public concerns that responsible authorities may be acting in the interests of practitioners rather than the public.
24. With no mechanism in place to independently monitor performance, there is little opportunity to ascertain how well or poorly a responsible authority is performing. To date, no Minister of Health has appointed an auditor under section 124 of the Act to investigate a responsible authority's performance. Without evidence of poor performance, a Minister of Health in the future is unlikely to appoint an auditor to investigate a responsible authority.
25. New Zealand's health responsible authorities are subject to fewer requirements concerning performance agreements, review and audit than authorities in other sectors in New Zealand, and health regulatory authorities overseas. For example, in the United Kingdom, the Professional Standards Authority for Health and Social Care (previously the Council for Healthcare Regulatory Excellence) scrutinises and oversees the organisations that regulate health professionals.

### *Options and impact analysis*

26. Most participants in the focus groups agreed in principle with monitoring responsible authorities' performance, recognising the need for stakeholders, including the Minister of Health and the public, to have confidence in the regulatory system. Some participants noted the usefulness of voluntary reviews of the Medical Council of New Zealand (Medical Council) and the Nursing Council of New Zealand (Nursing Council), carried out by the United Kingdom's Council for Healthcare Regulatory Excellence.
27. Focus group participants agreed that performance monitoring should focus on learning and continual improvement (rather than a "tick-box" exercise), and that setting the terms of reference should be a collaborative process.
28. The Ministry concluded that a mechanism by which responsible authorities' performance could be monitored was needed to provide an assurance to the public that the responsible authorities were performing their required functions and that their activities focused on protecting the public without being compromised by professional self-interest. This mechanism would provide a similar assurance to the Crown and would provide evidence on which the Minister of Health could decide to appoint an auditor to investigate a responsible authority's performance.
29. A mechanism for monitoring responsible authorities' performance could also provide regular opportunities for the Minister of Health to signal government expectations of responsible authorities, which may change over time in response to public demand or international practice. However, any expectations should align with the Act's requirements for responsible authorities and should require responsible authorities to act on changing expectations.
30. Publicly available information on each responsible authority's performance may provide an opportunity for all responsible authorities to learn from each other, promote good practice and increase consistency in policies and processes across the responsible authorities.
31. The table on page 7 (Assessment of options to ensure responsible authorities are focused on the principal purpose of the Act) assesses options associated with the following six variables in designing a review mechanism:
  - (i) Establishment of review terms of reference
  - (ii) Timing of development of terms of reference
  - (iii) Frequency of reviews

- (iv) Source of funding for reviews
- (v) Choice of reviewer
- (vi) Publication of review findings

32. The following criteria were used to assess the options for a model for performance reviews of responsible authorities:

- (i) the degree to which an approach will encourage responsible authority buy-in to the process and to continuous improvement
- (ii) the degree to which the approach and quality of the reviews will be consistent across the responsible authorities
- (iii) the degree to which the reviews would have credibility with stakeholders
- (iv) the practicality and efficiency of the performance reviews and the review process
- (v) the cost to government of the performance reviews.

### *Conclusions and recommendations*

33. When the criteria were applied to the options, the conclusions were that:

- (i) the focus of a performance review should be on providing stakeholders with assurance that the responsible authorities are carrying out their functions in the interest of public safety, and that the overall performance of each responsible authority is conducive to high public confidence in the regulatory system.
- (ii) the performance review terms of reference should be developed by the Ministry in consultation with responsible authorities, taking into account the views of stakeholders including employers, professional associations and consumer organisations. This approach is intended to increase the buy-in from the responsible authorities and other key stakeholders. The approach is practical.
- (iii) performance reviews should be required every five years with the terms of reference being set at least three years before the reviews take place. This approach allows responsible authorities to respond to reviews before addressing the terms of reference of a new review. A schedule should be developed so that not all responsible authorities undergo their performance review in the same year.
- (iv) on balance, the cost of the performance review should be borne by the responsible authorities (effectively by health practitioners and their employers). The cost would be dependent on the scope of the review and the size and number of registrants of a responsible authority.
- (v) the Ministry of Health should determine the reviewer, in consultation with the responsible authorities.
- (vi) responsible authorities should be required to make their performance reviews available on their websites. This approach allows the responsible authorities to take ownership of relationships with their stakeholders.
- (vii) the Minister would respond to the performance reviews and may require a responsible authority to respond to concerns following a review. This ensures there is follow up to the performance reviews and accountability for improvement.

34. The provision for compliance audits already in the Act should be retained.

## Assessment of options to ensure responsible authorities are focused on the principal purpose of the Act

Variables	Criterion 1	Criterion 2	Criterion 3	Criterion 4	Criterion 5	Total
	Responsible authority (RA) buy-in	Review consistency and quality	Stakeholder credibility	Practicality	Cost to government	
<b>Establishment of terms of reference</b>						
Developed by Ministry alone	1	n/a	3	5	n/a	9
Developed collaboratively with RAs	4	n/a	3	3	n/a	10
Developed collaboratively with wider groups of stakeholders	3	n/a	5	2	n/a	10
<b>Timing of the development of terms of reference</b>						
Set in a "just in time" fashion	1	2	2	1	n/a	6
Set well in advance	4	4	3	4	n/a	15
<b>Frequency of review</b>						
3 yearly	1	n/a	5	1	2	9
5 yearly	4	n/a	4	5	4	17
Greater frequency than 5 yearly	5	n/a	1	3	5	14
<b>Source of funding</b>						
RAs	2	n/a	n/a	n/a	3	5
Vote:Health	4	n/a	n/a	n/a	1	5
<b>Choice of reviewer</b>						
Decided centrally	2	5	5	3	3 (if funded by Vote Health)	19
Controlled choice by RAs	4	4	4	3	3 (if funded by Vote Health)	18
RA choice of provider approved by HWNZ	1	3	3	3	2 (if funded by Vote Health)	12
Independent choice by RAs	5	3	2	3	2 (if funded by Vote Health)	15
RAs self review	5	1	1	4	5	16
<b>Publication of review findings</b>						
Managed by RAs	4	n/a	3	4	3	14
As per s124 of the Act	2	n/a	3	4	2	11

Rating scale: n/a = not relevant to this criterion; 1= rates very poorly against the criterion; 2= rates poorly against the criterion; 3= meets criterion; 4= rates well against the criterion; 5= rates very well against the criterion

### (ii) Improve transparency about disciplinary proceedings relating to practitioners

#### *Status Quo*

35. The Act addresses the need to provide information about the outcomes of complaints or referrals to various parties (including the practitioner, the employer and the complainant), but it does not address what background information should be available to explain a responsible authority's decisions on complaints or referrals.
36. The Act requires responsible authorities to maintain a register of practitioners and sets out information that must be held on the register. This information includes the practitioner's name, qualifications, scopes of practice, and whether the practitioner has a current practising certificate (section 138). Section 149 of the Act requires responsible authorities to "from time to time publish the register". The responsible authorities have available on their respective websites a register of their registered health practitioners. However, the

registers do not include information about limitations or conditions on a practitioner as a result of a complaints proceeding. Nor do the registers hold information about a practitioner who may have been struck off the register in the past.

#### *Problem definition*

37. New Zealanders can find it difficult to understand responsible authority decisions in relation to complaints about registered practitioners. Responsible authorities do not generally provide information about investigations or decisions resulting from investigations to the public or, often, the complainant. Information about the process of an investigation, the rationale behind a decision and, in some cases the decision itself, can be very limited. This lack of information can foster a lack of confidence in a responsible authority as there is often a perception that the responsible authority is protecting the profession rather than the public.
38. The Act does not address what background information or evidence should be provided to explain responsible authorities' decisions about complaints relating to health practitioners. Nor does it address the issue of what information should be provided to the public generally, rather than to complainants, referrers or key institutional stakeholders. Responsible authorities each decide what information to make available and to whom. This can lead to inconsistencies and a lack of transparency around decision-making processes.
39. The absence of information in New Zealand about a doctor's track record was described as "remarkable" by Professor Ron Paterson in his book, *The Good Doctor: What Patients Want*<sup>1</sup>. He advocated the online disclosure of medical professionals' registration status, registration history and full details of any disciplinary findings that are not suppressed.
40. Internationally, the United Kingdom General Medical Council (GMC) and the Australian Health Practitioner Regulation Agency are more transparent in their decision-making than New Zealand's health responsible authorities. Within New Zealand, the naming
41. The Health and Disability Commissioner and the Health Practitioners Disciplinary Tribunal each has more transparent decision-making processes than the responsible authorities. Each of these organisations has an appropriate balance between transparency and individual privacy rights.
42. The Health and Disability Commissioner's complaints resolution jurisdiction extends to both regulated and unregulated health professionals. The Health and Disability Commissioner publishes many of its decisions and case notes in full detail, subject to considerations of privacy. The Health and Disability Commissioner has developed a policy about naming providers who are in breach of the Code of Health and Disability Services Consumers' Rights.
43. In practice, very few individuals are named under the Health and Disability Commissioner's naming policy. However the key difference from the perspective of individual complainants is that the Health and Disability Commissioner informs them of the outcome of their complaint and the rationale behind decisions. Currently, there is potential for information about a registered health practitioner who is subject to an investigation to be made publicly available by the Health and Disability Commissioner but not available through the relevant responsible authority with which the practitioner is registered. This inconsistency can increase the public perception that a responsible authority is acting to protect the practitioner rather than the public.
44. Hearings of the Health Practitioners Disciplinary Tribunal are public unless there is clear reason why they should not be. Decisions and penalties are published. The practitioner can ask for name suppression, which is normally granted (unless it is clearly in the public interest not to do so) until the Tribunal reaches a determination. If a disciplinary offence is

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<sup>1</sup> Professor Ron Paterson, "The Good Doctor: What Patients Want", Auckland University Press 2012.



established, publication of the practitioner's name is the norm. If a practitioner is found 'not guilty' and wishes to obtain permanent name suppression, this will usually be granted by the Tribunal.

45. Submissions to the 2012 review of the Act set out concerns from employers, health professionals and complainants about the lack of information relating to complaints and investigation outcomes. Submissions also confirmed that there is inconsistency about the reporting of outcomes and many consider that current responsible authority practices need to change to increase transparency.
46. Increased transparency about how complaints are investigated and the rationale for decisions will, in turn, contribute to assuring the public that responsible authorities are acting in the interests of the public rather than the interests of the profession. The focus groups agreed that transparency is important for public confidence in responsible authorities, but there was no common view about what level of transparency is appropriate. Concerns were also expressed about natural justice and the privacy of both practitioners and complainants.
47. The focus groups did not support a proposal that the Act should include more guidance to responsible authorities about the provision of information relating to complaints and disciplinary outcomes on the grounds that:
  - the Act gives sufficient direction about releasing information already
  - greater transparency may not equal greater public safety; ie fear of public exposure may deter practitioners voluntarily seeking assistance when they recognise that their practice may carry risks for consumers
  - there are better ways to increase public confidence in the work of responsible authorities, e.g. by increasing practitioners' ongoing professional development
  - legislation is not the place for "guidance"
  - legislation may be prescriptive and restrict flexibility
  - providing more public information is an additional cost.

#### *Options and impact analysis*

48. There are two separate but connected aspects of the proposal to provide more information about responsible authority processes in the determination of complaints:
  - (i) the needs of immediate stakeholders (ie the practitioner, employer and complainant) to be provided with more information about outcomes of complaints and referrals, and the need for more consistency of practice across responsible authorities in this regard
  - (ii) the need for information to be in the public arena as a means of providing public confidence in the regulatory system.
49. Approaches to providing transparency depend on whether only one or both aspects need to be addressed. Listed below is a range of options for improving transparency in responsible authority practice, which could be used singly or by combining two or more:
  - (i) retain the status quo, but include in responsible authority performance reviews an indicator relating to transparency about complaints and referral processes and outcomes
  - (ii) include in the Act a requirement that each responsible authority establishes and publishes protocols for providing information to complainants, informants and the public. The Act could require the responsible authorities to consult on the protocols and specify that consultation must include consumer groups, the Health and Disability Commissioner, the Ministry of Health, and employers. Responsible

authorities could also be required to consult with each other on this matter to agree a consistent approach across all responsible authorities

- (iii) include in the Act that responsible authorities must provide information to complainants, referrers and designated stakeholders (e.g. employers, ACC, the Ministry of Health) that conveys the evidence and rationale that supports their decisions
- (iv) either separately or in association with option (iii), require responsible authorities to develop and publish policies about the naming of parties involved in a complaint about a practitioner whose competence has been reviewed. The policy should show how the responsible authority balances rights to privacy for practitioners and complainants against the need for transparency (as a result, responsible authorities could provide case notes on their webpages, anonymised in accordance with the “naming policy” - the approach used by the Health and Disability Commissioner).
- (v) require responsible authorities to adopt the United Kingdom GMC model of providing registers that include the history of a practitioner’s registration together with detailed information about warnings, conditions and suspensions, except where privacy considerations outweigh public interests.

50. The table on page 11 (Assessment of options to ensure responsible authorities are focused on the principal purpose of the Act) shows an assessment of the options against the following criteria:

- Criterion 1: the extent to which affected stakeholders would be better informed.
- Criterion 2: the extent to which public confidence in the regulatory system may be raised.
- Criterion 3: the extent to which concerns about privacy might dissuade practitioners from self-referring for assistance.
- Criterion 4: the extent to which responsible authorities and practitioners will be impacted in terms of financial and other resources.

#### *Conclusions and recommendations*

51. It is recommended that options (iii) and (iv) are adopted. These options would have some impact on responsible authority processes and costs, but cost increases would not be high once processes were developed. There would be significant gains for all stakeholders in terms of transparency. An appropriate naming policy minimises the impacts on individual practitioners, both in terms of their self-referring behaviour and in terms of preserving privacy (through name suppression in cases that meet published criteria).
52. Option (i) is not recommended because, although it may result in improved transparency, movement towards greater public confidence is likely to be slow and uneven between the responsible authorities. Option (ii) is not recommended because public confidence and practitioner behaviour would depend on the nature of the protocol.
53. Option (v) would provide the highest degree of transparency in relation to the history of individual practitioners. But this option is not recommended because it does not provide as good a means for general reassurance to the public as option (iv) because a member of the public would be able to access information only in relation to known practitioners. It also provides less protection for practitioner privacy in that any person could access their record unless it was withheld for health reasons. This option would also impact more heavily on authority costs and workloads.

## Assessment of options to improve transparency of disciplinary proceedings relating to practitioners

	<u>Option</u>	<u>Criterion 1</u>	<u>Criterion 2</u>	<u>Criterion 3</u>	<u>Criterion 4</u>	<u>Total</u>
i	Maintain the status quo	3	3	5	n/a	11
ii	Include in performance reviews an indicator relating to transparency about complaints and referral processes and outcomes.  (Dependent on the option to implement performance reviews being agreed to)	3	3	3	4	13
iii	Include in the Act a requirement that each responsible authority establishes and publishes a protocol for providing information to complainants, referrers and the public. They could also be required to consult on it. This option could be instead of or in addition to Option ii above.	4	4	3	3	14
iv	Require, in the Act, responsible authorities to provide information to complainants, informers and designated stakeholders (e.g. employers, ACC, the Ministry of Health) that conveys the evidence and reasoning that supports their decisions.	5	3	4	4	16
v	Either separately or in association with option (iv), require responsible authorities to provide case notes on their webpages, anonymised in accordance with a "naming policy", similar to that of the Health and Disability Commissioner.	2	5	5	2	14
vi	Require responsible authorities to adopt the UK General Medical Council model of providing registers which include the history of a practitioner's registration together with detailed information about warnings, conditions and suspensions, except where privacy considerations outweigh public interests.	5	2	2	2	11

Rating scale: n/a = not relevant; 1 = rates very poorly; 2 = rates poorly; 3 = meets criterion; 4 = rates well against the criterion; 5 = rates very well against the criterion

**(iii) Provide greater recognition of the importance of team work and team communication across multi-disciplinary health practitioners**

*Status Quo*

54. Section 118 of the Act requires responsible authorities to set standards of clinical competence, cultural competence and ethical conduct but not standards for the skills that support integrated care. Responsible authorities provide practitioners with a range of documents (codes of ethics, conduct and practice, and standards), some of which make well-developed connections between team work, inter-professional communication and public safety, but others do not.

*Problem definition*

55. The Health and Disability Commissioner's submission to the 2012 review noted that many complaints to the Health and Disability Commissioner arise from failures in team work. There was a high level of agreement among other submitters about the importance of team work. The Act does not specify the need for responsible authorities to take into account the contribution that team work and inter-professional communication make towards public safety.

*Options and impact analysis*

56. The options are to:
- (i) retain the status quo
  - (ii) require that the responsible authorities jointly develop standards of inter-professional relationship (team work) and communication competencies that support integrated care
  - (iii) require each responsible authority to develop standards of inter-professional relationship and communication competencies that support integrated care for the professions they regulate.
57. Some original submissions and contributors to the focus groups considered that team work was a matter for employers, rather than a responsibility of individual practitioners. Apart from the fact that it is the behaviour of individuals that affects team work, this view overlooks the virtual team work of practitioners across primary and secondary care, and across private and public providers, which is part of integrated care.
58. The disadvantage of option (i), even if it involved some informal attempts to incorporate team work into existing codes, is that it may fail for lack of commitment on the part of one or more responsible authorities. An informal requirement may delay or even derail an important contributor to public safety, on which the Act is currently silent.
59. Option (ii) relies on effective joint management across the responsible authorities to operationalise the proposal. Implementation may be delayed, or may not be possible, if a collaborative approach were to stall or fail. New Zealand has no oversight agency for standard setting (such as the Australian Health Practitioner Regulation Agency). The option of establishing such an oversight body in New Zealand for standard setting was not considered since the costs would be disproportionate to any likely benefits.
60. Option (iii) is the preferred option because it achieves the policy objective of incorporating the contribution that team work and inter-professional communication make into the competencies for health practitioners. The effectiveness of each responsible authority independently developing policies on inter-professional relationships and communication may be more limited than a collectively agreed policy. It may be possible to achieve some degree of collaboration and consistency by including a relevant indicator in the performance reviews. This approach would not delay or prevent progress if agreement on a policy could

not be reached quickly, but would indicate an expectation that a collective agreement should be the ultimate goal.

#### *Conclusions and recommendations*

61. It is recommended that the Act is amended to expand section 118 (relating to the functions of responsible authorities) to require responsible authorities to include among their clinical competencies, those competencies and standards that support the achievement of team work, inter-professional standards and integrated care.
  62. It is further recommended that terms of reference for performance reviews for responsible authorities should encompass collaboration and consistency across responsible authorities' policies on inter-professional relationships and communication.
- (iv) Include the principles of transparency, integrated care and workforce flexibility and supporting workforce planning**

#### *Status Quo*

63. The purpose of the Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions. This overarching goal does not provide for the range of strategic responses to health care challenges that may be necessary to meet the challenge of delivering high standards of health care within sustainable budgets.
64. One response to future challenges is to encourage certain health professionals to take on new tasks and responsibilities, freeing up limited and expensive clinician time through the enhancement of existing roles and the development of new and innovative roles. Achieving this may include some appropriately trained health professionals extending their role while other health professionals 'let go' of tasks for which they have historically been responsible.
65. Another response to future challenges is to provide more health care services in the community. This approach may also require a shift in responsibilities, as well as changes in models of care between primary or community care and hospital care.
66. The Act does not include a mechanism to align the responsible authorities with strategic goals for the New Zealand health system.

#### *Problem definition*

67. The current legislative framework does not encourage responsible authorities to promote the objectives of workforce flexibility, integrated care, transparency and workforce planning. As strategic direction, ways of working and workplaces adapt to meet workforce and service demand, responsible authorities have a key role to play in ensuring practitioners have the skills and qualifications required to practise safely.

#### *Options and impact analysis*

68. Submissions to the review discussion document indicated little support for the notion that the Act should reflect newer paradigms, including integrated care. A prevalent response was that it is not the work of responsible authorities to consider workforce flexibility, and there was concern that focus on these issues would dilute the focus on public safety.
69. While public safety is now, and will remain, the central focus of occupational regulation, issues such as transparency, integrated patient-centred care, workforce flexibility and workforce planning are important. The two responses to future challenges outlined above (changing roles and models of care) both impact on the role and skills of the health practitioners concerned. While responsible authorities may not be responsible for instigating such approaches, they need to reflect those approaches within their functions

(eg setting standards and qualifications, and developing or reviewing codes of ethics and conduct).

70. It would be possible to establish within the Act that these issues are important contexts for the work of responsible authorities, while public safety remains the primary goal of the Act.
71. The options for a broader scope for the Act include adding:
- (i) specific provisions to provide for new paradigms
  - (ii) a broader purpose section in the Act to signal the importance of new paradigms.
72. Option (i) has the disadvantage of being more prescriptive and less flexible. Option (ii) would acknowledge and incorporate into the Act a requirement to have regard to newer paradigms, but in a manner that allows for changing circumstances and policy approaches to the delivery of health services over time. Recognition of a broader purpose for responsible authorities could be taken into account in performance review terms of reference.

### *Conclusions and recommendations*

73. Option (ii) is recommended – an expansion of the purpose of the Act to include transparency, integrated patient-centred care, workforce flexibility and workforce planning.

### **(v) Improve workforce data collection on which to base health workforce planning**

#### *Status quo*

74. At the national level, the Ministry has access to some data about health practitioners. Much of the data comes from the responsible authorities, but the data are not always robust or comprehensive across responsible authorities. The value of the data is, therefore, limited in terms of projecting workforce supply and demand. There is no legislative requirement for responsible authorities to collect workforce information, other than what is necessary to fulfil the requirements for registering and issuing practising certificates to practitioners.

#### *Problem definition*

75. New Zealand is a small country that competes for health practitioners within an international labour market. In order to effectively plan to meet the demand for health professionals, we need to monitor the flows into and out of New Zealand, the age profile of the different workforces, the areas where the country faces ongoing workforce shortages, and the mix of generalists and specialists the country needs.
76. Without good quality workforce data, we are unable to build a sustainable health workforce for the long term and will be more susceptible to workforce changes that, with good data, may have been predicted and prepared for. An inadequate workforce supply impacts on public safety on a number of different levels such as access to services and patient outcomes.

#### *Options and impact analysis*

77. In compliance with the Act, all responsible authorities collect information that is required to be held on a register of practitioners. This information is generally collected as part of the process for registration and to issue practising certificates. Many responsible authorities also use these processes to ask for other information. This additional information may include a practitioner's age, hours of work, primary and secondary workplace, and ethnicity. Responding to a responsible authority's request for additional workforce information is voluntary.
78. While practitioner response rates can vary across the responsible authorities and from year to year, some responsible authorities maintain a high response rate. For example, the

response rate for workforce surveys undertaken by the Nursing Council of New Zealand, Medical Council of New Zealand and Midwifery Council of New Zealand have each had response rates of between 95 and 100 percent.

79. The success of some responsible authorities in obtaining workforce information from a high proportion of their registrants demonstrates that this can be an effective mechanism to collect consistent workforce information that is pivotal to improving our understanding of the make-up of a particular workforce and the flows in to and out of the workforce. The responsible authorities provide the potential for a single point of data capture for the professions they regulate.
80. Amending the Act to require responsible authorities to collect individual-level workforce data (including name, date of birth, employer(s), place(s) of employment and hours of work) and to share those data with the Ministry will:
  - (i) ensure consistency of data collection across the responsible authorities
  - (ii) ensure a high response rate from registrants
  - (iii) provide the Ministry with access to robust data to determine supply and demand projections for an individual workforce and across a range of related workforces that may be impacted by a change in the health system (eg changing models of care).
81. During the review, a number of submissions considered workforce data. Among these, there was general support for workforce data collection and for enhancing data collection. However, some submissions raised concerns regarding potential additional costs, the privacy of health practitioners, and health practitioners feeling obliged to provide data for registration that would then be used for other purposes. There was also concern that linking the obligation to provide the Ministry with workforce information with the obligation to provide information required by the responsible authority for registration would cause problems for responsible authorities. They did not wish to be forced to decline applications for annual practising certificates on the basis that the workforce information was incomplete.
82. We do not propose that a practitioner's application for registration or a practising certificate be declined if the practitioner refuses to provide the required information. Refusing registration or a practising certificate to a practitioner who did not provide workforce information could remove a practitioner from the workforce for a reason that was unrelated to their qualifications, competence and fitness to practise. The benefit of receiving workforce information from a practitioner is outweighed by the detrimental impact to the public of refusing registration or a practising certificate to a practitioner who did not provide workforce information.
83. The cost of the requirement to collect workforce information should be minimal because most responsible authorities already collect some workforce information. The change will be to what information they collect. The provision of consistent workforce information for each of the regulated professions will contribute to our understanding of each profession, its current situation and its future sustainability. We anticipate the value of this understanding will outweigh any additional cost to responsible authorities.
84. Any data published by the Ministry would be anonymised or summarised to protect practitioners' privacy. Data will only be collected for a meaningful purpose.
85. We recommend that the performance review terms of reference address responsible authorities' obligations to improve, where necessary, the response rate to workforce data from practitioners. Over time, we anticipate that very few practitioners will refuse to provide the required information when they see how it is being used. Including the requirement in the Act may improve the response rate for workforce information within some responsible authorities.

### **Implementation of the recommended amendments in this Statement**

86. Amendments to the Act will be required to implement the recommendations set out in this Statement. Any new or amended legislation should be enacted with a reasonable lead-in time for stakeholders affected by new requirements. Media releases, and information on the Ministry website, should explain the changes and their implications for the public, stakeholders and other interested parties.
87. The Ministry would work with responsible authorities on the scope, terms of reference and content of performance reviews that are proposed in this paper (see Item (i) – performance reviews, starting on paragraph 20).

### **Monitoring, evaluation and review of the recommended amendments**

88. The effectiveness of the recommended changes to the Act will be monitored and reviewed as appropriate. Unless there are particular issues around the implementation of the recommended changes, the changes are likely to be reviewed in the context of any subsequent reviews of the Act.