In Confidence

Office of the Minister of Health

Cabinet Social Outcomes Committee

Policy approval for amendments to the Health Practitioners Competence Assurance Act 2003

Proposal

1 This paper seeks final policy decisions for amendments to the Health Practitioners Competence Assurance Act 2003 (the HPCA Act).

Relation to government priorities

2 The Government Policy Statement on Health 2024 – 2027 commits to reviewing the regulatory settings related to the health workforce. The National Party and ACT Party Coalition Agreement commits to consideration of an occupations tribunal, which has been considered through this reform.

Executive Summary

3 Timely, quality health services depend on the availability of qualified and competent health practitioners. Health workforce regulation is an important tool to assure the quality of health practitioners by maintaining appropriate standards of practice. However, the existing regulatory framework is outdated, inflexible and too slow to respond to wider health system needs. It impacts workforce availability, contributing to wait times and thus affecting patient safety.

4 My vision is for New Zealand to be an attractive place for both the domestic and international health workforce, and for patients to have greater access when it comes to the health services they need. This requires regulators to be focused on:

4.1 enabling access into the workforce through timely recognition of qualifications and registration of practitioners;

4.2 broad scopes of practice that recognise the skills and capabilities of all types of practitioners, to encourage greater access for patients;

4.3 working collaboratively on innovative solutions, such as digital health services, to deal with access challenges due to workforce shortages; and

4.4 responding quickly to changes in patient needs and service models.

5 I am proposing amendments to the HPCA Act to ensure regulation aligns with patient needs, health system policy and Government targets. These

amendments will enable me to direct regulatory authorities to respond to health system needs and require the regulatory authorities to report publicly on their plans and performance. I also propose a new ministerial review committee is established that can review decisions by regulatory authorities to refuse registration or impose conditions, responding to the National Party and ACT Party Coalition Agreement commitment to consider an occupations tribunal.

s 9(2)(f)(iv)

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Background

7 Timely, quality healthcare for all New Zealanders depends on the availability of a competent workforce. Health workforce regulation affects the supply of practitioners and how their skills can be used. Improving workforce regulation cannot fix complex and systemic health challenges on its own; however it can provide an environment that supports solutions.

8 In March this year, I publicly consulted on ways to reform our regulatory settings to reduce the bureaucracy and unnecessary barriers that slow down access to care, increase costs and make it harder for patients to get the services they need. Improved regulation is a key part of supporting my broader work programme to manage health workforce challenges, including the establishment of a new medical school, increasing the number of medical training places, and increased investment in primary care.

9 Feedback on consultation stressed that clinical expertise should not be undermined by any regulatory change. However, submitters did see value in regulatory authorities responding better to health system needs, and some ability for the Government to direct activity.

10 I am committed to responsive regulation that promotes flexible practice and innovation, while keeping patients safe, to achieve our goals for the health system, including to deliver on the Government's health targets. Better regulation can help us in a number of ways:

10.1 Regulation has an important role in setting broad scopes of practice to ensure practitioners are competent, and to support providers to recruit the workforce they need to innovate for the benefit of patients. For example, a flexible scope of practice has supported nurse-led chemotherapy clinics in Northland leading to faster cancer treatment, including avoiding patients having to travel to Whangārei. We need more of this innovation to meet the needs of patients.

10.2 We need regulation to support the expansion of our workforce with new professions, such as physician associates and associate psychologists. Regulators have sometimes been slow to adapt to changing system needs or new models of care due to professional resistance or lack of direction from government.

10.3 The Medical Council accredits training providers, like medical colleges, to offer specialist vocational training. We need the Medical Council to work with the Government to ensure specialist training providers produce the right number and types of specialists to meet our system needs.

10.4 Regulation also affects efforts to provide faster elective surgery. Private hospitals, which perform less publicly funded elective surgery, often lack accreditation to train, risking the future supply of specialists.

10.5 Wherever possible, we need fast-track registration pathways for international practitioners that recognise the value they provide our system through consistent and reasonable requirements.

The current approach limits our ability to address workforce challenges

11 We need clinical expertise to ensure decisions about what practitioners can do, and what qualifications are required are made with a full understanding of the clinical and technical issues. However, we also need sufficient oversight to ensure regulation is not focused on professional interest over that of patients.

12 Regulation under the current HPCA Act has contributed to high-quality and competent health practitioners in New Zealand. However, there are several features of the regulatory framework that make it harder to solve some of the key challenges facing our health system, including:

12.1 **Regulatory barriers**, which can delay or prevent patients from receiving services. This happens when regulators set unnecessarily high standards for individual practitioners. These barriers include long training programmes, strict supervision requirements, and not recognising the skills of professionals trained overseas.

12.2 **Profession-focused regulation**, where each profession regulates itself, does not consider broader health system needs and encourages patch protection. This can prevent practitioners from using their full range of skills and makes new professions, like physician associates, less available and useful, affecting patient access to care.

12.3 **A single approach to regulation,** which means statutory regulation or nothing, does not effectively manage the different levels of risk to patient safety posed by health practitioners. This leads to disproportionate regulation of some professions, limits innovation and productivity, and creates regulatory gaps and under-regulation of some workforce groups.

12.4 **Minimal oversight of the regulatory system**, both from the Government and the public, can reduce responsiveness to system needs. To deliver the range of service options that patients deserve, health service providers, particularly Health New Zealand, require regulation to be designed with the impact on the patient in mind.

12.5 **Inefficient and siloed regulators,** with 18 separate profession-funded regulators, deliver significantly variable performance and raise financial sustainability concerns for some regulators. This raises fairness issues for smaller or lower-paid professions due to fee-based cost recovery.

13 s 9(2)(f)(iv)

14 s 9(2)(f)(iv)

15 s 9(2)(f)(iv)

Overview of the proposed amendments

16 The current legislation is more than 20 years old and reflects an outdated view of workforce regulation. The current arrangements are heavily weighted toward the professions, with limited practical ability for the Government to assure performance and alignment of regulation with the needs of the health system. There are also no formal levers for the Government to intervene where the regulators go further than is needed to protect public safety.

17 I propose to establish new mechanisms to align regulation with patient needs, health system policy and targets. The intention is not to change the core purpose of health practitioner regulation, but to increase the responsiveness of regulation to support innovative health services while assuring patient safety, by providing for:

17.1 the Minister of Health to direct regulatory authorities

17.2 greater transparency and accountability of professional regulators

17.3 fast review of regulatory authorities' decisions

Aligning regulation with system needs through ministerial direction

18 Regulatory decisions have an impact on the supply and availability of the health workforce, and thus directly affect patient safety. I propose to amend legislation to ensure that decisions are focused on assuring competence, in the context of the needs of the health system. While I anticipate this will have a positive effect on workforce supply, I want to be clear that workforce regulation is not a supply control tool.

19 I propose that the Minister of Health be empowered to issue policy directions to regulators that relate to their functions and objectives, including to support delivery of health targets. This would be done in the same way that Ministers provide direction to Crown Agents and would exclude decisions made with respect to a particular person or persons. Similar powers are a feature of the Australian regulatory system, where health Ministers can provide directions to regulators on policies, procedures and standards.

20 Greater oversight and guidance are needed to ensure that regulatory authorities make decisions that benefit patients and the health system. As Minister of Health, I could, for example, direct regulators on:

20.1 Setting education and training standards that consider workforce planning, employment needs, and service delivery requirements. For example, medical colleges, authorised by the Medical Council, provide medical specialist training programmes. We need training providers to respond to the needs of the health system.

20.2 Taking advantage of new approaches to delivering health care, including the introduction of new technologies like digital health care and AI, and new professions like physician associates. These developments offer opportunities to improve access to care but also present new risks to patients and consumers. Regulators will need support from government to manage these risks.

20.3 Consistent**,** cross-profession standards. This includes setting clear guidelines for education, training, and practice that apply to all healthcare professionals, regardless of their specific field. By doing so, we can ensure that all patients receive high-quality care, no matter which healthcare professional they see.

20.4 Streamlining registration processes for healthcare professionals to reduce delays and ensure that qualified individuals can enter the workforce promptly.

21 I have considered alternatives to the power of direction. They are set out in detail in the attached Regulatory Impact Statement (RIS). The options considered were:

21.1 to amend the functions of regulatory authorities to include responsiveness to health system needs;

21.2 to change governance requirements to have broader range of expertise; and

21.3 to require rules to be approved by the Minister of Health before coming into effect.

22 I do not consider any of those options will have the desired effect. The power of direction allows specific guidance to be given to regulatory authorities, allowing them to focus on their core function of ensuring competent practice, rather than second-guessing government priorities. Decisions about clinical and technical matters need to be made by the experts. Ministers should not be directly involved in those decisions but should be able to guide on priorities and parameters.

Accountability of regulatory authorities will assure a high-level of performance

23 I also propose that regulatory authorities be subject to planning and reporting requirements of Crown Agents. This will assure greater transparency of regulatory activities and objectives. This will require a regulatory authority to develop, under consultation with the Minister and agencies a:

23.1 Statement of Intent (SOI), setting out their strategic intentions and how they intend to manage their operations to achieve their strategic goals and statutory responsibilities. A SOI must cover the upcoming four financial years and be produced at least every three years.

23.2 Statement of Performance Expectations (SPE), setting out the outputs they expect to deliver, such as the predicted number of registrations and other application, and anticipated timeliness.

Fast review of regulators decisions

24 I propose a new review function of decisions made by regulatory authorities. When regulatory authorities make decisions that unreasonably constrain or deny a practitioner's ability to practice, a swift review process will ensure that these issues are addressed promptly. This approach will help maintain a steady and efficient healthcare workforce, ensuring that qualified practitioners can continue to provide care without unnecessary delays.

25 The amendment will establish a statutory committee, appointed by the Minister of Health. A person will be able to request the committee review a decision by a regulatory authority to refuse them registration, or to put conditions on their practice.

26 This committee would be appointed on similar terms to the Health Practitioners Disciplinary Tribunal, which has a permanent Chair, and a panel of experts and laypeople to be drawn from to hear particular cases. It would be funded by the regulatory authorities, with a proportion of costs assigned to each regulatory authority based on the number of complaints expected to be heard.

27 The review committee will be able to review the merits of a decision. It will be empowered to:

27.1 refuse to hear a complaint if it is satisfied the original decision is not unreasonable;

27.2 refer a decision back to the regulatory authority to be reconsidered; and

27.3 substitute its own decision for that of the regulatory authority.

28 This proposal gives effect to the National Party and ACT Party Coalition Agreement commitment to consider establishing a health workforce occupations tribunal.

Ensuring effective implementation

29 I propose that the Director-General of Health review the policy and operation of the changes within five years of commencement, to ensure they are having the desired effect on regulation. The Director-General will report to the Minister of Health, who will present the report to the House of Representatives.

There is an opportunity to make improvements to the existing provisions.

30 The basic machinery of the existing HPCA Act remains broadly suitable, with the changes discussed above. There are opportunities to improve its functioning. I seek agreement to the detailed changes listed in the attached table (Annex 2).

31 There are some changes in the table that I wish to draw to Cabinet's particular attention. These are:

31.1 **Simplifying and clarifying the functions of regulators**. Regulators today often encourage or require health practitioners to consider factors beyond clinical safety. Specifically, I will revert the change made by the previous Government in 2019 to functions that added "(including competencies that will enable effective and respectful interaction with Māori)" to the existing provision requiring regulators to set standards of cultural competence. Patient-centred regulation is about ensuring patients receive access to timely, quality healthcare from the most qualified professionals for the job, while recognising that New Zealand is a multicultural country and that healthcare workers should be enabled to meet the unique needs of their patients. This places a strong emphasis on ensuring clinical safety.

31.2 **Enhancing provisions for regulatory authorities to take interim measures where a practitioner may be unsafe**. This would mean a single consistent set of provisions, allowing interim suspensions and conditions on practice, without notice, when an authority has reason to

believe a practitioner's conduct or competence is unsafe. Practitioners would be able to challenge these decisions through the new review mechanism described above.

31.3 **Empowering courts to issue injunctions**. This would stop people from providing health services that the HPCA Act does not permit them to provide. This will allow immediate intervention where a person is performing restricted activities protecting patient safety.

Implementation

32 The following is an indicative timeframe for new legislation:

Milestone	Timeframe
Cabinet approval of policy	August 2025

s 9(2)(f)(iv)

Cost-of-living Implications

33 The proposals in this paper are unlikely to have significant impacts on the cost of living.

Financial Implications

34 The proposals in this paper have no financial implications. Any costs are expected to be met within baselines.

Legislative Implications

35 The proposals in this paper will require legislation to implement. s 9(2)(f)(iv)

Impact Analysis

Regulatory Impact Statement

36 A RIS has been prepared and is attached as **Annex 1**. The Ministry's Quality Assurance Panel reviewed the attached RIS *Improving health workforce regulation* dated August 2025. The panel considers that the RIS 'Meets' the

quality assurance criteria and noted that the RIS is clear, concise, consulted, complete and convincing. The analysis is balanced in its presentation of the information. Impacts are identified and appropriately assessed.

Climate Implications of Policy Assessment

37 The Ministry for the Environment has confirmed that a Climate Implications of Policy Assessment is not required for the proposals in this paper.

Population Implications

38 This proposal is not anticipated to have specific population implications.

Human Rights

39 The proposals in this paper are consistent with the Human Rights Act 1993 and Bill of Rights Act 1990.

Use of external Resources

40 No external resources were used in the development of this paper.

Consultation

41 The Ministry has consulted on this paper and the attached RIS with Health New Zealand, the Public Service Commission, the Ministry of Business, Innovation and Employment, the Ministry for Regulation, the Department of the Prime Minister and Cabinet, the Treasury, the Ministry of Education, the Ministry of Social Development and the Accident Compensation Corporation.

42 In March 2025, Cabinet agreed to consult publicly on potential reform of health workforce regulation. The discussion document *Putting Patients First: Modernising Health Workforce Regulation* was published on 27 March seeking public views on options to ensure regulation is patient-centred, right-sized, future-proofed and streamlined [CAB-25-MIN-0063.01].

Communications

43 Subject to Cabinet's agreement to these proposals, I will make an announcement on the decision to draft new legislation.

Proactive Release

44 I intend to proactively release this paper after Cabinet decisions are made, with any redactions as appropriate under the Official Information Act 1982.

Recommendations

The Minister of Health recommends that the Committee:

1 **note** that the Government Policy Statement on Health 2024-2027 includes the review of regulatory settings, in order to retain, value and recognise the health workforce;

2 **agree** to amend the Health Practitioners Competence Assurance Act 2003 to:

2.1 provide that health workforce regulatory authorities will be subject to the accountability and directive requirements of the Crown Entities Act 2004 as if they were Crown Agents;

2.2 provide that there shall be a ministerial committee, constituted similarly to the Health Practitioners Disciplinary Tribunal, that can review and overturn decisions by a regulatory authority to refuse registration or put conditions on practice;

2.3 require the Director-General of Health to report to the Minister of Health on the effectiveness of the above changes within five years of their commencement, with the report to be tabled in the House of Representatives;

3 **agree** to the detailed changes set out in Annex 2;

4 **authorise** the Minister of Health to make minor and technical amendments through the drafting process;

5 **authorise** the Minister of Health to issue drafting instructions to the Parliamentary Counsel Office to give effect to the above recommendations.

Authorised for lodgement

Hon Simeon Brown
Minister of Health

Regulatory Impact Statement: Improving health workforce regulation

Decision sought	Analysis produced for the purpose of informing final Cabinet decisions for improvements to health workforce regulation
Agency responsible	The Ministry of Health | Manatū Hauora
Proposing Ministers	Minister of Health, Hon Simeon Brown
Date finalised	13 August 2025

The Minister's proposal is to amend the Health Practitioners Competence Assurance Act 2003 (the HPCA Act) to modernise and streamline the health workforce regulatory system, improve efficiency, and put patients at the centre.

The proposed legislation will include many of the existing provisions and retain most of the existing functions that are central to a health workforce regulatory system. The new proposals are focused on changing the environment in which those functions are performed, to align with the needs of the whole health system. We have identified two significant proposals that require impact analysis:

- Improving regulator alignment with health system needs and priorities
- Review mechanism for regulator decisions about individuals

Summary: Problem definition and options

What is the policy problem?

1. The fundamental policy problem is information asymmetry between health practitioners and their patients and purchasers of services. This problem is addressed through occupational regulation under the Health Practitioner's Competence Assurance Act 2003.
2. Based on previous reviews, engagements, and international research the Ministry has identified several problems with the current regulatory environment:
   - professional regulators (responsible authorities, RAs) under the HPCA Act have very little accountability to government or the public
   - there are limited incentives for regulators to adapt in response to new professions or ways of working
   - there is at least a risk that responsible authorities act in the interests of the profession rather than patients, and limited scope for intervention if they do.

What is the policy objective?

3. The broad policy objective is for health workforce regulation to support New Zealander's access to timely, quality healthcare.

4. The specific objective is to ensure New Zealand has an effective system of health workforce regulation, that supports public safety, and public confidence in practitioners. Part of public safety is access to services, so we are considering how to ensure regulation does not unnecessarily restrict entry to practice, or scope of practice, and mechanisms to align regulation with patient needs, health system policy and targets.

What policy options have been considered, including any alternatives to regulation?

5. The Ministry has considered both legislative and non-legislative approaches to achieve the desired objectives. Previous amendments in 2019 focused on addressing operational issues and attempted to improve collaboration among RAs within the existing regulatory framework. These amendments introduced a provision to amalgamate RAs if the Minister determines it would be in the public's interest.

6. The status quo option would involve working within these existing legislative provisions and using non-legislative levers available to the Ministry. This would involve increased information collection, expectation setting, monitoring and assurance activities.

7. Many of these elements are being progressed without any legislative change. However, the proposed legislation would make it easier to assure the changes in behaviour required to meet the policy objectives. Proposals to establish review mechanisms and directive powers cannot be achieved under the status quo as these will require new provisions in the legislation.

What consultation has been undertaken?

8. Over 2023 and 2024, the Ministry reviewed health workforce regulation, in engagement with key health workforce stakeholders. These stakeholders included the 18 responsible authorities under the HPCA Act, professional associations, Māori professional associations, self-regulating professional bodies, various medical colleges, unions and professional organisations. The key themes we heard from this engagement included:

    - Any changes to the regulatory system must not compromise patient safety.
    - There are opportunities for greater collaboration across professional regulators.
    - Professional identity and profession-specific expertise must be retained in the regulatory system.
    - Regulatory decisions should align with health system priorities and direction.

9. On 27 March 2025, the Government released a discussion document outlining ways to improve health workforce regulation. The discussion document was aimed at seeking patient views on changes to make regulation more efficient, patient-centred, and responsive. The consultation produced over 3000 submissions from patients, health practitioners, professional organisations, unions, RAs. The core themes of the consultation included concerns about the risk to patient safety of undermining regulatory independence; some agreement that greater transparency of regulators was needed; and concerns about the risks posed by currently unregulated health professions.

10. We also undertook engagement with other agencies on the specific proposals, relevant feedback is provided throughout this paper.

Is the preferred option in the Cabinet paper the same as the preferred option in the RIS?
11. Yes

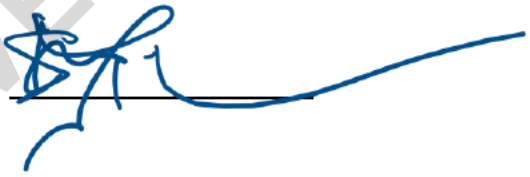
Summary: Minister's preferred option in the Cabinet paper

Costs (Core information)
12. For most of these proposals the potential costs to the Ministry and RAs are difficult to quantify at this stage but are expected to be low.
13. Any increased burden from greater accountability to government will have some additional cost due to increased administrative effort from RAs and the Ministry associated with increased planning, reporting, and monitoring requirements. For the Ministry these costs are expected to be minor and manageable within baselines.
14. Additional administrative costs for RAs are expected to be minor. The additional reporting and planning requirements will replace existing reporting requirements, and the RAs own planning functions. The RAs vary in size, capability and financial resource which may make it difficult for smaller RAs to accommodate increased administrative costs. If this cannot be addressed through shared services, then it may support the case for amalgamation of some RAs.
15. Annual fees paid by practitioners are not expected to increase as a result of these proposals. This is also a benefit for the government and the public, as a large proportion of regulated practitioners are reimbursed for their annual fees if they are employed in the public system.
Benefits (Core information)
16. Improving the accountability of RAs to the Government is expected to improve the quality, consistency and appropriateness of regulation.
17. It will also improve the incentives for RAs to focus on regulation that serves the priorities of the Government and the needs of the health system. This means strengthening processes and relationships between government, RAs, education providers and health providers to ensure that the skills and capabilities of regulated professions are aligned with the needs of the health system.
18. The key anticipated benefits of the proposals are: • Patients benefit from increased service availability associated with more flexible and responsive regulation. • Regulated professions are likely to benefit from increased flexibility of regulatory approaches and potentially decreased costs and burden. • In the long term, the overall proposal is likely to support more options for purchasers of health services through increased competition among professional groups able to offer similar services.
Balance of benefits and costs (Core information)
19. The analysis indicates that, given the likely low-cost impact, the benefits of the proposals are likely to outweigh the costs. We are not able to make specific monetised estimates, but the qualitative analysis indicates an overall positive effect.

Implementation
20. The proposals will require legislation. A bill is on the Government's Legislation Programme that will amend the HPCA Act. 21. The Ministry of Health will be responsible for implementation. This will require improvement to its stewardship function, particularly to strengthen its monitoring capability. For example, the Ministry will need to improve processes for collecting workforce data from the RAs to support Health NZ with workforce planning. This is expected to be managed within its baseline.
Limitations and Constraints on Analysis
Nature of proposals 22. The proposals will not significantly alter the purpose of the legislation, or the role and responsibilities of the RAs. Instead, they will influence the incentives and priorities of regulators through a change in accountability and new mechanisms to assure performance. The indirect nature of the expected outcomes means we are unable to give precise estimates of the effect – this will depend on how new mechanisms are used in the future. **Consultation** 23. The Ministry received considerable criticism on the discussion document released for public consultation. Concerns were raised that some of the questions were worded in a way that pushed respondents toward specific answers, rather than allowing them to freely express their opinions. The focus from submitters on the document did minimise how much public consultation informed this analysis.

I have read the Regulatory Impact Statement and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the preferred option.

Responsible Manager(s) signature:



Suzanne Townsend

Manager, Regulatory Policy

13 August 2025

Quality Assurance Statement	
Reviewing Agency:	**QA rating:** Meets
Panel Comment: he Ministry of Health QA panel has reviewed the Impact Statement titled "*Improving health workforce regulation*", produced by the Ministry of Health and dated August 2025. The panel considers that the Impact Statement **Meets** the quality assurance criteria. The Impact Statement is clear, concise, consulted, complete and convincing. The analysis is balanced in its presentation of the information. Impacts are identified and appropriately assessed.	

Section 1: Diagnosing the policy problem

What is the context behind the policy problem and how is the status quo expected to develop

24. Occupational regulation is necessary when the public is unable to assess the quality and safety of services for themselves. It is particularly important in healthcare where there is a high level of risk associated with the services provided by health practitioners (and the costs of adverse events are met by the public system or through ACC), and the services are essential for the public's wellbeing.

25. Given the obvious risks in health services, the public, and funders of services, need to be assured that the professionals they are consulting, or employing, are competent to practice safely.

26. For the health workforce this has traditionally been done through professional regulators, established by statute, who take responsibility for the standards, practices, and discipline of their own professions. While current regulation has been effective in ensuring high standards for practitioners, the independent and siloed nature of the regulators has been highlighted as an issue that inhibits the health systems ability to meet future needs.

27. Over the past several decades, a shift from strict professional self-regulation has occurred in many countries. This has often been due to regulatory failures to protect the public or to reduce complexity from a fragmented regulatory structure. There has also been increasing recognition of the role that regulation has in fostering the flexibility and innovation needed to meet population health needs.

There is an existing regulatory regime

28. The Health Practitioners Competence Assurance Act 2003 (the HPCA Act) provides a framework for the regulation of health practitioners to ensure they are fit and competent to practise their professions. The HPCA Act builds on the framework created by earlier legislation, in particular the Medical Practitioners Act 1995. All the major concepts of the Medical Practitioners Act have been carried forward into the HPCA Act, adjusted where necessary to generic terms to provide a framework that can apply to all health practitioners, not just doctors.

29. 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."

30. Under the HPCA Act, 18 authorities are established and charged with registering and issuing annual practising certificates to suitably qualified health professionals who meet competence, conduct and fitness requirements. Members of the authorities are appointed by the Minister of Health, except for 4 members of the Medical Council, and 3 members of the Nursing Council, who are elected by the members of the relevant profession. A majority of the members of any professions must be practitioners of that profession.

31. These 18 authorities are responsible for 26 health professions and administer more than 100 scopes of practice. The current responsible authorities are:

    - Chinese Medicine Council of New Zealand
    - Chiropractic Board
    - Dental Council
    - Dietitians Board

- Medical Sciences Council of New Zealand
- Medical Radiation Technologists Board
- Medical Council of New Zealand
- Midwifery Council
- Nursing Council of New Zealand
- Occupational Therapy Board
- Optometrists and Dispensing Opticians Board
- Osteopathic Council
- Paramedic Council
- Pharmacy Council
- Physiotherapy Board
- Podiatrists Board
- Psychologists Board
- Psychotherapists Board

32. The key provisions of the Act are:
    - Only individuals registered with a particular authority can claim to be practitioners of that profession (title protection).
    - Regulated health practitioners can only perform health services that are within the scope of practice of their profession.
    - Certain activities are restricted to particular health practitioners.
33. Every health practitioner who practises in a regulated profession in New Zealand must be registered with the relevant responsible authority and hold a current annual practising certificate (APC) issued by that authority. Responsible authorities develop scopes of practice that describes the services a registered practitioner is competent to provide. Practitioners must practice within their scope.
34. The HPCA Act bars any individual from claiming to be a practitioner of a regulated profession, or in any way imply that they practise or are willing to practise a regulated profession, unless they are appropriately qualified, registered with the relevant authority, and hold a current APC.

Ministerial powers with respect to responsible authorities

35. The responsible authorities are independent statutory entities established under the HCPA Act. The Minister of Health has limited powers to guide and direct the authorities, with some more substantial powers that are intended to address regulatory failures, including:
    - to require an independent audit of authorities and request statistical information
    - powers to appoint (and remove) authority members, to determine mechanisms to facilitate resolution of disputes over scopes of practice.
36. The regulators are established by statute and members are appointed by the Minister. While there is oversight of regulatory activity in the form of annual reports provided to Parliament, and periodic performance reviews, the authorities largely perform their functions independently from government.

Previous reviews and amendments

37. The Ministry of Health reviewed the Act between 2007 and 2009. In 2012 a second, more strategic, review examined the underlying policy settings of the Act. The 2012 review, which included public consultation, identified key areas where legislative change could enhance the Act. These areas all related to the strategic direction of the health system, including quality and safety, improving public confidence, patient-centred care, multi-disciplinary teams, transparency, collaboration and consistency, and workforce sustainability.

38. These reviews led to the Health Practitioners Competence Assurance Amendment Act 2019, which gave effect to many of the recommendations from both reviews. The changes included improvements to efficiency of processes, increased transparency of disciplinary decisions, introduced performance reviews of authorities, required authorities to provide more workforce data, and introduced a regulatory power to amalgamate existing authorities when it is in the public interest.

39. While no formal review of the 2019 Amendment Act has taken place, the fact that similar regulatory challenges have persisted suggests that they have not had the desired impact. However, that could be due to poor implementation of those changes or not enough time has elapsed to see improvements.

International trend of greater oversight and accountability

40. The responsible authorities have a high degree of independence from government to prevent undue political influence over regulatory decisions. This is a common feature of professional regulation, particularly in relation to decisions on individual practitioners, which can be important to establish public credibility and trust.

41. Independence from the regulated profession is also desirable in an occupational regulatory system. If a regulator is dominated by members of the profession or is behaving as an advocate this can lead to professional capture, where regulators are acting in the interests of the profession instead of the public.

42. While independence from government can support greater trust in regulatory decisions it can also lead to less accountability and regulators disregarding the priorities and policies of the government.

43. To address issues of accountability significant reform of health practitioner regulatory systems has taken place in many countries. There is a growing interest in more pluralist and inclusive governance models with greater public participation, thereby reducing the risk of capture of the regulator by vested professional interests.

44. The establishment of the Australian Health Practitioners Regulatory Authority (AHPRA) and the Professional Standards Authority (in the UK) are both examples of significant governance reform. These oversight entities support professional regulators to perform their regulatory functions, provide pathways for public interaction with regulation, and create mechanisms for governments to issue policy direction to regulators. In addition to better performance, the purpose of these entities is to ensure coordination of regulators, to develop common standards and encourage team-based (interdisciplinary) models of care.

What is the policy problem or opportunity?

45. The basic model of statutory regulation to respond to asymmetric information remains sound. However, the current regulatory regime is not necessarily responsive to system needs and is inflexible in approach.

46. Under this regime, for example, regulation of physician associates, which is considered necessary for them to be widely used in health services, is expected to

come into effect in 2026, more than a decade after they started working in New Zealand. There were similar delays with formalising regulation of nurse practitioners.

47. Profession-based regulation has resulted in 18 regulators who vary greatly in size and capacity. While some back-office functions and services are shared, there is limited cooperation between the regulators.

48. The Ministry has identified several problems with the HPCA Act that contribute to the problems identified:

    - regulation is focused solely on the competence of individual practitioners, and does not take into account other safety-related matters such as workforce shortages
    - responsible authorities have very little accountability to government or the public; there are also no incentives for authorities to work collaboratively
    - regulation is difficult to adapt in response to new professions or ways of working
    - the way that responsible authorities are organised and funded creates challenges for smaller authorities, and creates inefficiencies more broadly
    - there is a perception that responsible authorities act in the interests of the profession rather than patients.

The HPCA Act focuses solely on individual competence based on identified professions, and does not enable broader safety issues to be taken into account

49. The purpose of the HPCA 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". It is appropriate for health workforce legislation to centre on the competence of individual practitioners. However, there is a balance to be struck between risk and benefit.

50. The current system does not take into account the safety risks from workforce shortages. It can exacerbate them, for example, by making it difficult for overseas-trained practitioners to practise in New Zealand through difficult processes, and supervision requirements.

51. Public health and safety can also be enhanced through innovative and collaborative models of care. Many modern models of care involve new professions (such as physician associates), new roles for existing professions (such as nurse-led clinics), or a team of different practitioners working together. A narrow focus on the competence of individual practitioners in existing professions does not enable these models.

The HPCA Act does not make regulators accountable to the public, government, or their professions, or require them to take wider system issues into account

52. There is no requirement in the existing scheme for regulators to consider public views, or wider system needs. The HPCA Act contains very few levers to make responsible authorities accountable or responsive to government or their professions, and none to make them accountable to the public (or health service users).

53. The Minister of Health has limited levers to influence the work of responsible authorities:

    - performance audits
    - appointment of members
    - amalgamation of authorities

- ‘soft’ levers such as letters.

54. None of these levers are effective means to influence the regulator’s priorities or ensure they take system issues into account.

55. Although professions regulated under the HPCA Act are largely self-regulated, the HPCA Act does not actually require responsible authorities to be responsive or accountable to their professions. Most board members are appointed by the Minister of Health – only the Medical Council and the Nursing Council have elected members, and these members are a minority on the board. Practitioners cannot withhold registration fees if they are unhappy with their authority’s performance, nor do they have any other means to address poor performance.

56. There are no mechanisms to make responsible authorities accountable or responsive to patients or the general public.

57. The lack of effective levers and accountability mechanisms means that professional regulation generally does not take into account wider systems issues. These include workforce shortages (as discussed above), but also other issues and priorities such as value for money, timely care, and the benefits of integrated health services.

Multiple professional regulators working in isolation is unnecessary and inefficient

58. In our current system, we expect all regulators to carry out the same functions despite significant differences in size, complexity, and risk (RAs range from 500 registrants to 80,000, and from one scope of practice to 45).

59. RAs are reliant on practitioner fees to fund their activities, which has led to financial sustainability issues for some smaller regulators. Some RAs have expressed concerns about the “one-size-fits-all” approach to RA functions and expectations, rather than basing these on RA revenue, size or risk profile. They have also raised equity concerns regarding high registration fees for lower paid (often female-dominated) professions.

60. These size discrepancies flow through into matters of financial sustainability, which has been raised as a concern by smaller RAs and limits their capacity for regulatory innovation and best practice.

What objectives are sought in relation to the policy problem?

61. The overall objective is for New Zealand to have a health workforce that supports the Government’s aim to provide timely, quality care to patients. The objective for regulation is that it supports that goal by ensuring that practitioners are competent to practice, and that practitioners who are competent are able to practice to the top of their ability.

62. Health workforce regulation has a significant impact on the supply of practitioners and their capabilities. The government is seeking to establish mechanisms to ensure regulation aligns with patient needs, health system policy and targets. The intention is that this will result in more responsive regulation that is able to support innovative health services. This would mean regulatory effort being focused on considering the highest priorities, rather than requiring particular regulatory decisions.

63. To support more responsive regulation the government is also seeking:

    i. greater value for money from regulators through a stream-lined structure

    ii. alternative (less costly and intrusive) regulatory mechanisms for lower-risk health practitioners

    iii. to increase the level of public engagement in regulatory decisions.

64. These objectives will need to be balanced against the importance of retaining an effective and independent practitioner certification system, informed by professional expertise, which is required to maintain public confidence in the high standards of practitioners.

65. The future health workforce regulatory system needs to be able to respond to wider system priorities, in addition to ensuring that health practitioners are competent and fit to practise their professions. This is a key change, which may require regulators to take a broader view of the impact of decisions and in particular, consider the availability of practitioners and how regulation can empower the workforce to develop and utilise their skills to the greatest extent possible.

66. Workforce regulation (and regulators) can further support the development of future models of care by:

    i. supporting practitioners, of all professions, to expand their capabilities and increase their contribution to the health system

    ii. collaborative practice and decision making (e.g. accrediting education providers and cross-profession supervision)

    iii. supporting the use and development of emerging workforce groups (e.g. physician associates)

    iv. more efficient recognition and registration of overseas practitioners

    v. enabling innovative health care services (e.g. digital health providers).

67. The challenges facing the workforce and the health system are intersecting and complex. To address these will require a coordinated and systemic approach to improving service delivery models, workforce capability, education and training, employment settings, commissioning, and investment.

68. The current regulatory settings contribute to these challenges and impede some solutions. Regulatory settings for the health workforce need to enable multi-disciplinary models of care, along with increased access to services and expanded workforce distribution. This includes ensuring regulatory settings are responsive to health system priorities while still recognising the need for profession-specific expertise.

What consultation has been undertaken?

69. The Health Workforce Strategic Framework sets out priority issues for New Zealand's health workforce and identifies several key areas of change to address these systemic issues. One of these key areas was the regulatory settings that assure safety and consistency of care, without unduly restricting how skills and capabilities are developed or utilised.

70. Following the completion of the Framework, the Ministry undertook a review of health workforce regulatory settings from 2023 to 2024. This review included engagement with key health workforce stakeholders to understand how the current regulatory framework contributes to workforce challenges and how it could be improved.

71. These stakeholders included the 18 responsible authorities, professional associations, Māori professional associations, self-regulating professional bodies, various medical colleges, unions and professional organisations such as Hauora Taiwhenua. The key themes we heard from this engagement included:

    - Any changes to the regulatory system must not compromise patient safety.
    - There are opportunities for greater collaboration across professional regulators.

- Professional identity and profession-specific expertise must be retained in the regulatory system.
- Regulatory decisions should align with health system priorities and direction.

72. On 28 March 2025, the Government released a discussion document outlining ways to improve health workforce regulation. The discussion document was aimed at seeking patient views on changes to make regulation more efficient, patient-centred, and responsive.

73. The discussion document received 3306 submissions. Most submissions (over 80%) were from individuals. Of these, 43% identified as members of the health workforce, while 36% identified as members of the public or patients. A smaller portion, 3%, identified with both the health workforce and another group, such as unions, advocacy groups, or professional bodies.

Section 2: Assessing options to address the policy problem

What criteria will be used to compare options to the status quo?

74. The proposed options will be assessed based on the following criteria:

Proportionate	Will the option improve the ability to proportionately manage risks posed by activities performed by health practitioners?
Public confidence	Will the option improve public confidence in the quality of health practitioners and health services?
Efficient	Will the option support: • a cost-effective and cohesive approach to setting and applying professional standards • streamlined processes for registering practitioners • sustainability of regulators • greater coordination between regulators and the government.
Future-focused	Will the option support adaptable regulation that supports innovation and greater productivity within the health system?
Implementation	Is the option simple to implement and cost-effective for health practitioners, responsible authorities, and the government?

What scope will options be considered within?

75. Due to the significant associated risks, the information asymmetry between health providers and consumers can only be addressed through regulation. Options considered are amendments to the existing legislation, rather than a fundamental rethink of the regulatory approach.

What options are being considered?

76. This analysis considers two proposals:

- **Proposal One: improved alignment with health system priorities.** This proposal is about ensuring regulator decisions take into account the context of the health

system and government priorities. It includes considering options to allow for greater accountability of regulators to government and the public, and powers of direction.

- **Proposal Two: review of regulator decisions.** This proposal considers a new mechanism for review of individual decisions.

Proposal One: Improving accountability and responsiveness

77. This proposal is essentially about to the relationship between the regulators and the government. Workforce regulation has a large effect on the availability and the productivity of the workforce, which directly influences the services patients can access.

78. Independence of regulatory decisions is an important aspect of public confidence, with about 60% of submitters on the recent public consultation opposing any ability for the government to direct regulators. For quasi-judicial functions, such as disciplinary procedures and decisions on individual applications for registration, independence is essential. Consultation respondents were concerned that increased government involvement in health regulation could lead to political interference, reduced patient safety, or poorly informed decisions.

79. However, oversight can aid confidence, with about 40% of submitters favouring some level of government oversight. Submitters highlighted that there could be benefits in government involvement, such as better workforce planning and accountability.

Option 1: Status quo

80. There is no formal power for a Minister to direct an authority. The Minister can influence an authority's policy (decision process or framework) by informal means, e.g. writing letters, or through the performance review process introduced in 2019. Periodic performance reviews were established as part of an amendment to the HPCA Act in 2019 – they provide a mechanism for the Minister to gather specific information about an RAs operation and performance of its functions. This process allows greater transparency of an authority's activities, capabilities, and priorities, but does not allow any formal direction with respect to performance improvement.

Option 2: Greater ministerial oversight of regulator activity

81. Under this option, the Minister would be able to set expectations to guide regulatory authorities, supported by changed functions. For example, the authorities could be required to consider particular health system priorities when developing scopes of practice. This would preserve the independence of authorities, who would be able to make decisions that conflicted with government policy, as long as they had genuinely had regard to the relevant policy.

82. This would require a relatively small legislative change. For example, legislation could require that an authority must have regard to government policy. It could also require an authority to consult relevant entities, especially Health New Zealand, when establishing priorities and developing scopes of practice and qualification requirements.

83. This option would allow the government to set clear expectations to guide the authorities' work. Authorities are likely to work to meet the expectations, and to focus on areas where the health system is considering reform. However, there would remain limited ability to assure performance.

Option 3: Changed governance provisions

84. This option would amend the current provisions for appointments to authorities. At present, authorities must have a majority of practitioner members. Changing this provision to require a broader range of expertise could improve the effectiveness of

decision-making. It would also allow the range of expertise to be tailored to the needs of the particular moment.

85. This option would be simple to implement. It would require a minor legislative change, such as requiring the minister to appoint members with the appropriate range of expertise to fulfil the duties of the authority. That is the standard provision for statutory appointments.

Option 4: Ministerial approval of rules made by authorities

86. Currently, regulatory authorities make rules, in the form of scopes of practice and qualification requirements, independently of the government. In other regulatory systems, such as medicines, or the occupational regulation of lawyers and conveyancers, the rules are given effect through an Order in Council. This mechanism would mean a minister must concur with the rules, providing a level of political review.

87. This option would require a minor legislative change. It would mean authorities had an incentive to respond to government priorities and avoid overreach. It may raise a concern about ministerial interference in clinical and technical matters, but these are unlikely to arise in practice – ministers rely on technical expertise and do not attempt to substitute their own judgement.

Option 5: Stronger directive mechanisms and reporting requirements

88. This option would apply the accountability mechanisms from the Crown Entities Act. In particular, it would allow the Minister to direct an RA to give effect to Government policy. This power would be constrained by the overall purpose of the Act to assure public safety, so could not be used to require unsafe decisions by regulators

89. This option would allow the Minister to:

    i. Give policy direction to RAs that relate to their functions and objectives (except for directing decisions relating to individual practitioners), including requiring collaboration or joint decision-making.

    ii. Participate in setting strategic direction and priorities.

    iii. Request information on an authority's operations and performance at any time.

    iv. Set clear expectations for performance (such as improving registration timeframes) and for the Ministry to actively monitor.

90. The potential downsides of this power are increased administrative costs, and potential effect on public confidence. In the recent consultation, about 56% of people said regulators should remain independent from the Government, while 37% of submitters said the Government should have some ability to intervene if decisions negatively affected workforce availability. If the public consider the government is unreasonably influencing regulatory decisions, that may impair their confidence in practitioners. However, all directions must be public, and must fit with the overall purpose of the Act, which mitigates this concern. The Social Workers Registration Board is a Crown Agent, and that has not led to widespread public concern about political interference.

How do the options compare to the status quo?

	Option One – Status Quo	Option Two – greater guidance to regulators	Option Three – broader appointments to authorities	Option Four – ministerial approval of rules	Option Five– powers to direct regulators
Proportionate	0	+ Clear guidance on system priorities would improve regulator response to them	+ A wider range of member qualifications would be broaden thinking and improve response to system needs.	+ Standard approach to regulatory instruments to have a political approval.	+ Clear direction on system priorities would improve regulator response to them. Offset by increased administrative burden
Public confidence	0	0 Effect likely to be negligible. Authorities would retain independence.	0 Likely to have a negligible effect. Authorities would better understand public views.	0 Likely negligible effect.	- Likely to have a negative effect, but mitigated by increased responsiveness and limits of direction powers
Efficient	0	+ Improvements in regulatory processes likely in response to government priorities	0 May marginally increase efficiency through greater expertise being available.	0 May be marginal efficiency improvement though incentive to respond to government priorities	++ Clear direction will improve responsiveness, coordination and consistency
Future-focused	0	+ Clear guidance will improve regulators' ability to respond to changing system needs.	+ Broader qualification requirements allow the relevant expertise to be appointed to respond to changing circumstances	0 No appreciable effect	++ Regulators can be directed to focus on the most important system needs as they change.
Implementation	0	- Greater effort from central government to develop guidance and monitor performance	- Minor change to existing appointment process	- Minor increase in administrative effort.	- - Significantly greater effort from government to direct and authorities to respond

Overall assessment	0	+	0	0	++

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

91. **On balance, the Ministry prefers option Five** as likely to have the most positive effect on the future flexibility of the workforce, and efficiency of regulators. Options Two and Five are similar. Option Two is simpler to implement than Option Five, as policy is indicated in existing instruments, which would require only moderate amendment to outline workforce policy. Option Five allows more detailed direction, which is likely to improve efficiency and responsiveness, but comes with increased administrative complexity from the need to make more detailed directions. The effect on public confidence is unclear. The 2025 consultation showed that people value both independent regulators, and responsiveness to health system needs. The practical effect would depend on how directive powers were used, but is likely to be neutral or negative. That view would change if public confidence were seriously affected. Options Three and Four are not likely to achieve the objectives.

Proposal Two: Review of regulator decisions

Reviewing decisions about registration and practising scope of individual practitioners

92. This section looks at options for review of RA decisions to decline registration or set conditions on practice. The current arrangements do not adequately respond to the risk of workforce shortages. In particular, there is concern that the current approach is making it difficult for overseas-trained practitioners to practise in New Zealand.

Option 1: Status quo

93. Health practitioners can challenge an RA decision to deny their registration through the courts. This is expensive and difficult, especially for practitioners living in other countries; this is likely to contribute to legal challenges being rare.

94. There is significant public concern about international practitioners being unable to register in New Zealand, especially in the context of workforce shortages.

Option 2: Review committee

95. Under this option, there would be a statutory review committee, empowered to review RA decisions on applications for registration, including any conditions placed on practice. A review committee would be capable of reviewing the merits of an RA decision, as opposed to the courts who will only assess the process followed.

96. The purpose of this committee would be to review decisions that appear to unreasonably constrain or deny the ability of a practitioner to practice. The review committee would be constituted similarly to the Health Practitioners Disciplinary Tribunal; with a single permanent member the Chair, appointed by the Minister, and a panel of suitably qualified experts and laypeople that could be brought in to consider any particular case. The Chair would have the authority to:

- Form a committee of clinical and regulatory experts to assess applications.
- Consider applications from individuals to review decisions about their registration.
- Reject review applications if satisfied the decision is not unreasonable.
- Overturn decisions by an RA to deny registration or apply conditions to a health practitioner.
- Make recommendations to the Minster on systemic issues with regulation

97. This option would provide a quicker and cheaper, therefore more accessible review of decisions than the courts.

Option 3: Occupations Tribunal

98. The coalition agreement between the National Party and the ACT Party commits to improving recognition of overseas medical qualifications and experience, including “consideration of an occupations tribunal”.

99. An occupations tribunal would function similarly to the review committee outlined in option 2, although would likely be more expensive to establish and maintain.

100. The Tribunal would provide a cheaper, faster and more accessible appeals process (particularly for overseas practitioners) compared to the court process.

How do the options compare to the status quo?

	Option One – Status Quo	Option Two – Review committee	Option Three – Occupations Tribunal
Proportionate	0	+ Provides a more accessible avenue for redress for practitioners who feel they have been treated unfairly	0 Provides a more accessible avenue for practitioners, but likely to be more time consuming for applicants and respondents than option 2
Public confidence	0	++ Should address public concerns about overseas-trained practitioners being unable to register in NZ	++ Should address public concerns about overseas-trained practitioners being unable to register in NZ
Efficient	0	+ Much more cost-effective and practical for practitioners, but will create extra work for the Crown and regulatory bodies	0 Much more cost-effective and practical for practitioners, but will create extra work for the Crown and regulatory bodies (compared to status quo and option 2)
Future-focused	0	+ Should identify system issues if RAs not recognising modern models of care	+ Should identify system issues if RAs not recognising modern models of care
Implementation	0	- Relatively minor legislative amendment	-- More significant legislative amendment.
Overall assessment	0	+	0

What option is likely to best address the problem, meet the policy objectives, and deliver the highest net benefits?

101. **Option Two is likely to be the best option**. It provides an avenue for merits review of decisions, which is lacking in the current system. It has lower implementation and operational costs than Option Three.

Is the Minister's preferred option in the Cabinet paper the same as the agency's preferred option in the RIS?

102. Yes

What are the marginal costs and benefits of the preferred option in the Cabinet paper?

Affected groups *(identify)*	**Comment**	**Impact**	**Evidence Certainty**
Additional costs of the preferred option compared to taking no action			
Regulated groups	No additional costs expected for regulated parties. Any additional costs for regulators, which might be recovered through fees, should be more than offset by expected efficiency gains.	Low	Low
Regulators	Additional ongoing costs are likely to be incurred from additional planning and reporting requirements associated with the accountability changes. There is opportunity to mitigate this from the shared service proposal.	Low	Low
Others (eg, wider govt, consumers, etc.)	No additional costs for the public anticipated. Additional government administrative costs anticipated – low impact that can be managed through baseline.	Low	Low
Total monetised costs	Not estimated		Low
Non-monetised costs		Low	
Additional benefits of the preferred option compared to taking no action			
Regulated groups	Increased flexibility likely to mean some professions can get benefits of regulation at a lower cost.		low
Regulators	Cost savings likely from shared service proposal. Estimate of $3.5 million likely too high, but significant benefits available.		Low
Others (eg, wider govt, consumers, etc.)	Patient benefit from increased flexibility of regulation more easily allowing new professions and ways of working.		Low
Total monetised benefits	Not estimated		

Non-monetised benefits		Medium	Low

Section 3: Delivery

How will the proposal be implemented?

103. The proposals will require amendments to the Health Practitioners Competence Assurance Act 2003.

104. The Minister will be requesting that Cabinet authorise him to make decisions on minor and technical matters during the drafting of the Bill. We do not anticipate requiring further consultation on an initial draft of the Bill prior to introduction. The proposals in this impact analysis have already been informed by public consultation and discussion with key stakeholders.

105. s 9(2)(f)(iv)

Stage	Proposed timing
Ministerial consultation	31 July – 13 August 2025
Policy decisions	SOU – 20 August 2025 Cabinet – 25 August 2025

s 9(2)(f)(iv)

106. The Ministry has established the Health Workforce Regulation Steering Group – a group of senior leaders across the Ministry and Health NZ to oversee implementation. This will include embedding new ways of working, for the Ministry and RAs.

107. No additional funding is required for implementation of the preferred option. The proposals are focused, in part, on driving greater efficiencies in regulation and the Minister expects this to be managed through baselines. The Ministry will need to strengthen its stewardship function with respect to RAs, particularly its monitoring capability, which will be achieved through reprioritising existing resources.

108. Further regulatory impact analysis will be undertaken for any proposal to regulate a new profession or to significantly change the regulatory status of an existing profession.

How will the proposal be monitored, evaluated, and reviewed?

109. The monitoring of RA activity will continue to be the responsibility of the Ministry of Health. The Ministry will work with RAs, and other agencies, to evaluate effectiveness of the new legislation on improving the alignment of health workforce regulation to the needs and priorities of the broader health system. This will include assessment against the policy objectives:

Annex 2 Table of detailed change proposals

No.	Problem identified	Legislative proposal	Reasoning	Benefit to patients
Area 1: Offences				
1	• No way to immediately stop unqualified or unregistered practitioners from providing services that pose a serious risk to public safety.	• Empower courts to issue injunctions, prohibiting people from continuing to practise when not permitted to do so by the Act.	• An interim injunction could be obtained quickly, and the person could be sanctioned for contempt of court if they failed to comply.	• Protects patients, who may not be aware of the risk they face when obtaining services from an unqualified or unregistered practitioner.
2	• Current maximum penalties insufficient to sanction those who commit the most serious breaches of the Act.	• Increase maximum fines for offences including unqualified practice (currently $10K) and unauthorised performance of restricted activities (currently $30K). • Provide separate, higher maximum penalties for offences committed by a corporation.	• Set penalties that take into account inflation since 2003 and the need to deter unlawful actions that risk serious harm to patients. • A higher maximum penalty for corporate offending is justified, as corporations may have greater resources than individual practitioners.	• Protects patients, who may not be aware of the risk when obtaining services from a person who is not authorised to provide them. • Protects patients, who may not be aware of the risk when obtaining services from a corporate practice that is not authorised to provide them.
3	• Hard to successfully prosecute a person falsely claiming to be a qualified or registered practitioner.	• Prohibit saying or doing anything likely to give the impression that the person is a qualified or registered practitioner.	• Easier to obtain a conviction, as no longer need to prove the behaviour was "calculated" to create a false impression.	• Helps to protect patients, who are not always well placed to determine a practitioner's qualifications.
Area 2: Registration and issuing of practising certificates				
4	• Past misconduct may not be identified and considered when a person applies for registration.	• When determining fitness for registration, past orders and adverse findings can be considered.	• Disciplinary history is relevant when deciding if a person should be registered.	• Protects patients because a poor disciplinary record may indicate the applicant would be an unsafe practitioner.
5	• An applicant with disciplinary conduct issues may be a risk to the public if permitted to practise without conditions included to address those issues.	• When registering a practitioner, an RA may include conditions in their scope of practice to address identified disciplinary conduct issues.	• Currently, there is authority to include conditions to ensure competent practice, but not to prevent risks arising from misconduct.	• Benefits patients by putting in place measures to protect them from possible misconduct by a practitioner.
Area 3: Notifications and complaints				
6	• An RA may not be made aware of a practitioner's conduct that poses a risk of serious harm to the public.	• Extend current provisions for reporting to RAs so they cover practitioners' misconduct, not just practice below required level of competence.	• Misconduct can also pose risk to patients, e.g. inappropriate sexual behaviour, so should also be reportable.	• Protects patients because it enables RAs to investigate practitioners whose conduct may pose a risk to their safety or wellbeing.
7	• When notified of a conviction that is not related to professional practice, taking disciplinary or therapeutic measures is sometimes an unwarranted use of an RA's resources.	• Provide that an RA has the option of taking no further action when notified of a conviction.	• This may be an appropriate response to a less serious conviction that is a "one-off", i.e. not related to underlying issues.	• No direct impact on patients.
8	• Undue delays can occur when an RA refers a complaint to the HDC, which then refers it back to the RA.	• When an RA or the HDC receives a patient-related complaint, it must promptly consult the other agency on the action to be taken.	• Avoids the delays caused by the requirement for an RA to stop investigating while the matter is before the HDC. The consultation provision should reduce the risk of parallel investigations.	• Benefits patients with complaints about practitioners because it means that some investigations can be completed more quickly.
Area 4: Unsafe practitioners				
9	• Provisions for interim suspension are inconsistent, and overall, do not adequately protect the public, e.g. some provisions do not permit orders to suspend the practitioner to be made without notice.	• Single provision for RAs to impose conditions or suspend a practising certificate, if necessary without notice, where risk of serious harm to the public or is otherwise in the public interest.	• Interim measures should be able to be taken quickly, to address immediate risk, and should remain in place until final decisions have been taken.	• Patients benefit from immediate protection where there are grounds to believe a practitioner poses a serious risk of harm.
10	• When an RA revokes an interim suspension, the practitioner's competence may still be in doubt unless conditions are imposed.	• Provide that, when an RA revokes an interim suspension, it may include conditions in the practitioner's annual practising certificate.	• It gives an RA the option of deciding that the right to practise can be restored, subject to conditions that ensure safety.	• Protects patients from risks posed by practitioners who are permitted to resume practice but whose conduct or competence is still being investigated.
11	• An RA can impose conditions on a practitioner with a health condition, e.g. random testing for substance use, but they may continue to practise and not comply with the conditions.	• If an unsafe practitioner with a health condition fails to comply with restrictions imposed by an RA, their registration may be suspended.	• Conditions are imposed because they are necessary for patient safety, so a noncompliant practitioner should not be permitted to practise.	• Protects patients from risks posed by practitioners with health conditions who do not observe necessary restrictions on their practice.

Annex 2 Table of detailed change proposals

Area 5: Disciplinary processes				
12	• Some issues would be better addressed by restorative processes or conciliation.	• Provide that an RA can use informal or restorative processes in dealing with complaints and notifications, and that a PCC may refer a complaint to conciliation before completing its investigation.	• Enables more timely resolution of less serious matters and, where appropriate, the use of processes that are mana-enhancing for the complainant and the practitioner.	• Benefits some patients who make complaints, as it gives them an opportunity to be involved in resolving the issue.
13	• Undue delays caused by process requirements and restrictions on delegation.	• Process changes – include enabling some cases to be decided "on the papers", HPDT Chair empowered to rule on procedural matters. • RA may delegate powers of interim suspension and appointing a PCC.	• Reduces the number of hearings and meetings of the full HPDT panel, resulting in cost and time savings. • May be administratively simpler if an RA decides to delegate these powers.	• May benefit some patients who have complained about a practitioner, as disciplinary action will occur more promptly.
14	• The range of penalties available to the HPDT is insufficient to cover all circumstances.	• Provide for HPDT to order a practitioner to meet conditions while suspended. • Increase maximum fine (currently $30K). • Provide for lifetime cancellation of registration.	• Imposing conditions may assist a practitioner to practise safely when they resume practice. • Maintains punitive impact of penalty. • In the most egregious cases, appropriate to preclude the possibility of ever resuming practice.	• Reduces the risk to patients when a suspended practitioner resumes practice. • Patients may benefit from a stronger deterrent for the most serious practitioner misconduct.
Area 6: Scopes of practice				
15	• A profession should not appear to be able to reserve an activity to itself by including it in one of its scopes of practice.	• State that scopes of practice may overlap.	• Clarifies that two or more professions may legitimately provide the same services.	• Helps to ensure that patients may choose between different types of practitioners for certain health services.
16	• Unclear that a practitioner can be authorised to provide additional services within their scope of practice once they have met the RA's requirements.	• Provide that a scope of practice may include additional authorised activities.	• If a practitioner meets requirements set by the RA, they should be able to carry out additional activities specified in their scope of practice.	• Improved access to services. • Patients can check that a practitioner is authorised to provide the specified services.
Area 7: Miscellaneous				
17	• Some provisions may cause doubt, e.g. not clear on the face of the Act that a competence review can be conducted while a practising certificate is suspended.	• Explicitly state that the suspension of a practising certificate does not prevent an RA from proceeding with a competence review.	• It would make no sense if a practising certificate had to be reinstated for the sole purpose of enabling a competence review to be undertaken.	• No direct impact on patients.
18	• Insufficient accountability mechanisms for HPDT.	• Require HPDT to produce an annual report, which the Minister must present to the House.	• Greater transparency and appropriate HPDT operations to be subject to parliamentary scrutiny.	• No direct impact on patients.