Briefing

Improving accountability and decision-making of health workforce regulators

Date due to MO:	2 September 2024	**Action required by:**	9 September 2024
Security level:	IN CONFIDENCE	**Health Report number:**	H2024048465
To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☐		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, Strategy, Policy and Legislation	s 9(2)(a)
Suzanne Townsend	Acting Group Manager, Health System Settings, Strategy, Policy and Legislation	

Minister's office to complete:

☐ Approved ☐ Decline ☐ Noted

☐ Needs change ☐ Seen ☐ Overtaken by events

☐ See Minister's Notes ☐ Withdrawn

Comment:

Improving accountability and decision-making of health workforce regulators

Security level:	IN CONFIDENCE	**Date:**	2 September 2024
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This briefing provides a range of options on which we are engaging with key stakeholders to ensure that health workforce regulators are accountable and operating in a way that acknowledges the needs of the wider health system. It seeks your approval to amend the engagement and consultation process to provide you with more detailed proposals to discuss with your Cabinet colleagues s 9(2)(f)(iv)

Summary

2. The HPCA Act is a broad and enabling piece of legislation. While there are benefits to this, it has led to a system where there are 18 different regulators (responsible authorities, RAs) that adopt different approaches to regulating the health workforce, with limited regard to the impact on wider health system needs. The functions of RAs (e.g. standard-setting and accreditation) are often performed in isolation of other RAs, leading to inconsistencies between professions.

3. You have requested advice on options to ensure that health workforce regulators are accountable and operating in a way that acknowledges the needs of the wider health system.

4. This briefing provides options to address this, on which the Ministry is consulting:

   a. Amending the HPCA Act to strengthen expectations of RAs;

   b. Amending the HPCA Act to give direction and review authority for the Minister, DG or Ministry of Health;

   c. Establishing a cross-profession strategic body with oversight of fewer regulators; and

   d. Establishing a single regulatory body with profession-based business units.

5. We expect you are likely to see the best outcomes through a combination of options.

6. To develop these ideas with key stakeholders, the Ministry proposes reordering its engagement approach [H2024044779 refers] to extend targeted engagement. The updated approach allows for more effective engagement with key stakeholders with a negligible impact on overall delivery timelines, including providing you policy options by the end of 2024 s 9(2)(f)(iv)

7. This briefing was shared with the Health Workforce and System Efficiencies Committee (HWSEC) for comment.

Recommendations

We recommend you:

a) **Note** the range of options on which the Ministry of Health is engaging with key stakeholders to ensure health workforce regulators are accountable and operating in a way that acknowledges the needs of the wider health system

b) **Indicate** whether you wish to discuss these options further with Ministry of Health officials **Yes/No**

c) **Agree** to the updated engagement and consultation plan to develop change proposals for health workforce regulatory settings **Yes/No**

d) **Note** that the updated engagement and consultation plan s 9(2)(f)(iv)

Maree Roberts
Deputy Director-General
Strategy, Policy and Legislation
Date: 2 September 2024

Hon Dr Shane Reti
Minister of Health
Date:

Improving accountability and decision-making of health workforce regulators

Understanding the HPCA Act in its current state

8. The HPCA Act is a broad and enabling piece of legislation. While there are benefits to this, it has led to a system where there are 18 different regulators (responsible authorities, RAs) that adopt different approaches to regulating the health workforce, with limited regard to the impact on wider health system needs. The functions of RAs (e.g. standard-setting and accreditation) are often performed in isolation of other RAs, leading to inconsistencies between professions.

9. The independence of RAs—from government and each other—means there are few incentives to collaborate or coordinate with each other, or mechanisms for government to provide direction and encourage consistency and efficiency across regulators.

10. While the HPCA Act provides the Minister of Health some powers to ensure RAs comply with legislation, these powers are disproportionate and reactive, so therefore mostly ineffective in providing system direction and accountability. It has also been challenging for the Ministry of Health (the Ministry) to fulfil its function as steward of the health system in relation to health workforce regulation, as this is not explicitly provided for within the Act. As a result, the Ministry has limited levers to influence and support RAs.

11. Furthermore, there are serious concerns about the financial sustainability of some smaller RAs under the current framework. For some regulators, a significant proportion of funds needs to be held in reserve for potential disciplinary actions. This inhibits innovation and improvement in areas such as processing times of registration applications. The financial status of some RAs is having an adverse impact on their ability to perform certain regulatory functions.

We are engaging with key stakeholders

12. In July 2024, we briefed you on our approach for engagement and consultation on the future of health workforce regulation, including the HPCA Act [H2024044779 refers]. We have since commenced phase 1 (initial targeted engagement).

13. So far, as part of phase 1, we have engaged with a number of key stakeholders, including RAs, medical colleges, HNZ, professional associations, and advocacy organisations. These engagements have been open and constructive, and participants have valued the opportunity to discuss health workforce regulation.

14. We have used these engagements to test our understanding of the problems with the HPCA Act as well as refine options to amend the Act to address these problems. As a result of the engagements to date, we are considering the below options, on which we would like to engage further with key stakeholders.

Options to improve accountability and decision-making

15. The Ministry previously briefed you on options for consultation to improve the way the health workforce is regulated [H2024037240]. These were presented in three broad shifts, supported by proposals for consultation:

    a. Utilise the full competence of our workforce through responsive scopes of practice

    b. Establish alternative forms of regulation commensurate to risk to public safety

    c. An accountable and efficient regulatory structure.

16. You asked for further advice on the third shift. Specifically, smaller scale options to amend the HPCA Act to ensure regulators were accountable and operated in a way that acknowledged broader system needs. A range of options on which we are engaging is outlined below. We expect that a combination of options would likely result in the best outcomes.

Smaller scale options to amend the HPCA Act

Amending the HPCA Act to strengthen expectations of RAs

17. Through the review process and engagement so far, we have identified changes to the legislation that would improve accountability and decision-making. These include:

    a. broadening consultation processes;

    b. changing the requirements for board composition;

    c. improving enforcement provisions;

    d. changing discipline provisions to include wider consumer perspectives; and

    e. improving cultural safety requirements.

18. We expect that other minor legislative changes would continue to be identified through the engagement process.

19. One approach to ensure regulators are accountable and operating in a way that acknowledges the needs of the wider health system would be to make such expectations explicit in legislation.

20. Section 118 of the HPCA Act lists the functions RAs are expected to undertake. There is an opportunity to strengthen the language in this section to be more explicit and directive.

21. As an example, section 118 states that RAs are "to liaise with other authorities appointed under this Act about matters of common interest". This language could be strengthened to increase the expectation beyond just liaising with other RAs and to agree on matters of common interest.

22. This could go some way to increasing accountability and transparency, and reducing regulatory silos. But it would not in and of itself create the necessary change for increased productivity, cohesion, and responsiveness. For example, there would still need to be consideration of how the Minister and/or Ministry provide strategic direction for regulators.

23. The Ministry would also need to consider the practical implications of this option. For example, resourcing and financial constraints make it difficult for some RAs to fulfil their current functions. So, increasing the expectations on RAs alone may not be sustainable or effect significant change.

Amending the HPCA Act to give direction and review authority for the Minister, DG or Ministry of Health

24. There is an opportunity through this process to provide greater cross-profession strategy and direction for the health workforce. This could be in the form of including additional powers in the legislation for the Minister, Director-General and/or Ministry of Health to manage, monitor, oversee or direct the regulators.

25. This may include authority to:

    a. give Ministerial direction to regulatory bodies;

    b. set expectations and performance standards for regulatory bodies;

    c. require regulatory bodies to consider the Government Policy Statement in making decisions and setting priorities;

    d. review decisions made by regulatory bodies; and/or

    e. replace a board with commissioners in the event of significant underperformance.

26. Any of these options would require significant change to the current regulatory design, namely:

    a. changing the status of the regulating bodies from statutory independent bodies to another form of entity;

    b. giving the Minister a different status and role; and

    c. giving the Ministry greater monitoring and oversight functions.

27. Profession-based regulators would retain independence over decisions that require profession-specific knowledge and expertise, such as setting clinical competency standards.

28. While this option may increase system accountability and guide regulatory settings to reflect the direction and priorities of the wider health system, additional Ministerial levers would mark a shift from the foundational principle of regulatory independence in the current legislation.

29. Furthermore, additional powers alone may not lead to significant practical change. For example, maintaining the same number of RAs would make consistent implementation of any cross-profession direction difficult as there would still be 18 different decision-makers.

30. We would need to engage further with the sector on this option to manage these challenges.

HPCA Act amendments to update regulatory structure

31. We are engaging on the above options in addition to other potential amendments to the HPCA Act that would update the way our workforce regulatory system is structured. Conversations to date have taken a "form follows function" approach, where we discuss

the outcomes we all seek from the regulatory system before considering the most effective structure to achieve them. Below are two options on which we are engaging.

Establishing a cross-profession strategic body with oversight of fewer regulators

32. To keep pace with the increasing complexity of health needs, and to provide coordination and quality assurance of regulation, many jurisdictions (e.g. Australia and the UK) have established oversight agencies that provide a range of support functions for regulators and consumers.

33. A cross-profession body that provides strategic direction and oversight for regulators could be established to increase accountability and efficiency. The body would provide system-level direction and/or set expectations of regulators to acknowledge the shared spaces across regulators, while leaving space for clinical expertise and professional uniqueness in decision-making.

34. We expect the body would act with regard to government policy while remaining at arm's length from government.

35. The body could also provide an opportunity to bring together and align processes (e.g. administrative functions) and infrastructure (e.g. IT) to create more a more efficient, cost-effective, and sustainable system.

36. We propose that the establishment of this body be complemented by a reduction in the number of regulators. It is difficult for a country as small as New Zealand to justify 18 independent health workforce regulators, and some RAs have raised concerns about their financial sustainability as standalone regulators.

37. Reducing the number of regulators would increase system efficiency, sustainability, and cross-profession collaboration.

Establishing a single regulatory body with profession-based business units

38. Under this option, the 18 RAs would be amalgamated into a single regulatory body, which would be responsible for the entire regulated health workforce. The regulatory body would still have profession-based business units to ensure professional identity and expertise is retained.

39. This would simplify the regulatory structure, enable consistency across the health system, and provide for greater economies of scale in operating costs. It would also provide the opportunity to streamline registration pathways, with consistent registration requirements and processes for overseas practitioners.

40. Establishing such a body as a Crown entity means it would retain an appropriate level of independence to perform its functions, while giving the Minister responsibility for overseeing and managing its performance. The Minister's roles would include:

    a. appointing and maintaining an effective governance board;

    b. providing the Crown entity board with clear performance expectations;

    c. setting the direction of the Crown entity;

    d. monitoring and reviewing operations and performance; and

    e. managing risks on behalf of the Crown.

Engaging with stakeholders going forward

41. Key stakeholders continue to raise ideas and provide valuable feedback on the proposed regulatory shifts through our targeted engagement process.

42. To continue to leverage this, we propose a reordering of our engagement and consultation approach to see longer targeted engagement with key stakeholders, including Health New Zealand, through to November 2024, and public consultation in early 2025.

43. The amended timeline would allow us time to provide you with more refined change proposals for you to discuss with your Cabinet colleagues by the end of the year, s 9(2)(f)(iv) [H2024044779 refers].

44. We expect to provide you with policy proposals on the approach to workforce regulation, informed by our targeted engagement, by the end of 2024 to consider and seek agreement from your Cabinet colleagues, in order to begin public consultation in early 2025.

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

46. A comparison of the new timeline to the original engagement plan is at **Appendix 1**.

47. These dates are indicative, s 9(2)(f)(iv)

Comments from HWSEC

48. This briefing was shared with the Health Workforce and System Efficiencies Committee (HWSEC) on 28 August 2024. It provided the following comments:

    a. There was agreement that responsibility should be placed on regulators to ensure their decisions, policies and processes address New Zealand's health needs.

    b. It is important that professional expertise in regulatory decision-making remain for functions where it is necessary (e.g. setting clinical competency standards). But there may be areas where it is appropriate to require regulators to develop common policies (e.g. informed consent).

    c. Consideration of the options requires a clear articulation of what each option would seek to achieve.

    d. It will be important to find the right balance between the Minister/Ministry providing direction to regulators and regulatory decisions remaining at arm's length from government.

    e. HWSEC also noted the change fatigue in the health workforce, and any structural change should take lessons from the experiences establishing Te Pūkenga and Health New Zealand.

49. These comments align with matters the Ministry has been considering through the policy development and engagement process.

50. We accept the premise that the workforce may be experiencing change fatigue and that there are lessons to be learned from previous experiences. It is our position that while

change to the structure of the regulatory system would have significant impact for RAs, the workforce itself would feel minimal immediate disruption to their day-to-day work, even with the largest change. Instead, the workforce (and most importantly communities) should experience the long-term benefits of a responsive and accountable regulatory system that have been discussed in previous advice [H2024037463 and H2024037240 refer].

51. Previous advice has provided additional detail on options being considered for consultation [H2024037240 refers]. Furthermore, targeted engagement with key stakeholders is supporting us to further refine proposals for public consultation, including a clearer description of their benefits and risks.

Next steps

52. You may wish to discuss these options with Ministry officials at your regular meeting.

53. Ministry officials will update you on progress of engagement through the weekly report.

ENDS.

s 9(2)(f)(iv)