MINISTRY OF HEALTH
MANATŪ HAUORA

Briefing for decision

Health workforce regulation: Options for discussion document

Date due to MO:	3 December 2024	**Action required by:**	10 December 2024
Security level:	IN CONFIDENCE	**Reference:**	H2024056015
To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☒		
Proactive release:	This **title** is proposed by the Ministry of Health for proactive release: ☒		

Contact for telephone discussion

Name	Position	Telephone
Maree Roberts	Deputy Director-General, Strategy, Policy and Legislation	s 9(2)(a)
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Minister's office to complete:

☐ Approved	☐ Decline	☐ Overtaken by events
☐ Needs change	☐ Seen	
☐ See Minister's Notes	☐ Withdrawn	

Comment:

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Briefing for decision

Health workforce regulation: Options for discussion document

Security level:	IN CONFIDENCE	**Date:**	3 December 2024
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This briefing seeks your views on detailed options proposed for consultation on health workforce legislation reform.

Summary

2. Following your agreement to high-level settings for the future of health workforce regulation [H2024054398], we are progressing with changes to the Health Practitioners Competence Assurance Act 2003 (the HPCA Act).

3. These changes are intended to ensure workforce regulation is proportionate, sustainable, and supports the Government's overall goals for the health system.

4. You have agreed that changes to the statutory framework include an expanded purpose, underlying design principles, and governance provisions, including directive powers, to support better regulation. We seek your views on the proposed options to achieve these changes, to be included in a discussion document for release early 2025.

5. In addition to the above changes, we also propose consulting on changes to increase public involvement, allow proportionate regulatory mechanisms, and improve efficiency.

6. For most of these changes we propose consulting on the full spectrum of options that could be progressed. We want to make sure that you are comfortable with the range of options presented.

Recommendations

We recommend you:

a) **Note** you have agreed to advance changes to the purpose, design principles, and governance provisions in health workforce legislation

b) **Note** the Ministry's advice that there may also be useful changes to be advanced with respect to public involvement, proportionate regulatory mechanisms, and efficiency

c) **Note** that you have agreed to consult via a discussion document s 9(2)(f)(iv) s 9(2)(f)(iv)

d) **Note** this briefing seeks your views on detailed options to be included in the discussion document

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e) **Indicate** your comfort with consultation on the options in this briefing in the checkboxes marked throughout — **Yes/No**

f) **Note** that the Ministry will prepare a discussion document reflecting your views on matters for consultation

g) **Note** the draft discussion document and a covering Cabinet paper will be provided to you on 12 December

h) **Note** that we will inform responsible authorities of our intended approach for engagement in December 2024

Maree Roberts	Hon Dr Shane Reti
Deputy Director-General	**Minister of Health**
Strategy, Policy and Legislation	Date:
Date: 02 December 2024	

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Health workforce regulation: Options for discussion document

Context

1. The Health Practitioners Competence Assurance Act provides a framework for the regulation of health practitioners to ensure they are fit and competent to practise their professions. This framework has a significant impact on the availability, accessibility, responsiveness, productivity, and quality of the health workforce.
2. Present-day models of care rely on the collaborative efforts of various professions working together to achieve patient outcomes and are not siloed according to a practitioner's profession.
3. As outlined in the Government Policy Statement on Health 2024-2027 (the GPS), further implementation of models of care that optimally use all skills and capabilities within a health care team will be important to meet the health challenges of the future. Teams of health care providers, working to their full scope of practice, will improve continuity of care, and reduce fragmentation and duplication to deliver better health outcomes.
4. As our approach to delivering health care evolves, so too must the system that is responsible for regulating it.
5. Workforce regulation (and regulators) should further support the development of these models of care by:
   a. recognising the full competence of health practitioners to maximise output
   b. cross-profession decision making (e.g. accrediting education providers)
   c. supporting the use and development of emerging workforce groups (e.g. nurse practitioners).

Current regulation does not support delivering on the GPS

6. The current regulatory system does not always support the ways in which health care needs to be delivered. Features of the current system that can make it harder to solve some the key challenges facing our workforce include:
   a. Narrow view of safety, focussing only on risk and not benefit can limit workforce availability.
   b. Singular approach to regulation, that means licensing or nothing, leads to disproportionate regulation that reduces productivity.
   c. Profession-focussed regulation that does not take account of wider health system needs and incentivises patch protection.
   d. Profession-funded regulation that raises equity issues for smaller or less well-paid professions, and significantly variable performance and financial sustainability.
   e. Minimal oversight of the regulatory system, both from the Government and the public, may reduce responsiveness to system needs.

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Workforce regulation can support our goals

7. 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.

8. This is a key change, which would 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.

9. The options we intend to consult on are designed to shift the regulatory system in the following ways:

   a. **Regulation that supports overall system goals**, we want to regulate the health workforce in a way that aligns with the Government's overall aims for the health system.

   b. **Proportionate regulation**, we want to regulate to minimise the risk of harm to the public without unnecessarily restricting practitioners' scopes of practice or consumers' access to services.

   c. **Sustainable regulation**, we want a regulatory system that performs efficiently and effectively, and that can keep up with changing models of care.

10. We also want a modern, high-quality regulatory system. The proposed changes provide an opportunity to improve upon the core regulatory functions, such as disciplinary and registration processes.

11. We acknowledge that achieving the Government's health objectives cannot be done through legislation alone. They require a systematic approach to developing the health workforce and can only be done in partnership with education agencies and providers, health regulators, health agencies and entities, employers, and local communities.

Patient safety remains the priority

12. Legislation should assure safety and consistency of care, while not unnecessarily restricting how skills and capabilities are developed or used.

13. We expect change to require a new piece of legislation, but with much of the content of the current Act replicated, with some refinement (see **Appendix**). Parliamentary Counsel advise that a new piece of legislation would be best to ensure the statute reflects modern legislative practice.

Summary of targeted engagement

14. Ministry of Health officials have conducted targeted engagement with key stakeholders on this work programme, including RAs, professional associations, Māori professional associations, Hauora Taiwhenua Rural Health Network, self-regulating professions, the Council of Medical Colleges, and unions.

15. Key themes from consultation included:

   a. Any changes to the regulatory system must not compromise patient safety;

   b. There are opportunities for greater collaboration across professional regulators;

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c. Professional identity and profession-specific expertise must be retained in the regulatory system;

d. Regulatory decisions should align with health system priorities and direction.

16. These themes are reflected in the options presented in this paper.

Options for consultation

17. You previously agreed to changes to the purpose, principles, and governance provisions in the legislation [H2024054398 refers]. We propose to consult on a revised purpose and statutory design principles that reflect your earlier decisions. The options for consultation set out in the remainder of this paper reflect the spectrum of options available. We do not intend to articulate a preferred option in consultation to ensure we get a broad range of views, rather than reactions to our proposals.

18. We will work through the detailed costs and benefits of the options s 9(2)(f)(iv) That will be informed by the response to the discussion document.

Purpose

19. You have agreed to a revised purpose for legislation. The purpose of legislation will be to protect the health and safety of the public by:

a. Ensuring health practitioners are competent to practise

b. Ensuring workforce regulation supports the needs of the health system, including availability of practitioners.

20. We propose to consult on an example revised purpose statement. The precise wording will be up to the Parliamentary Counsel.

The purpose of this Act is to promote the health and wellbeing of the public by ensuring that health practitioners are competent to practise, and that health workforce regulation supports overall system priorities. **Are you comfortable consulting on this purpose statement? Yes ☐ No ☐**

Principles

21. You have agreed that the principles informing the regulatory framework should:

a. Support and align to overall health system objectives

b. Support safe innovation in practice and models of care

c. Be informed by professional identities and knowledge

d. Support the health system to protect, promote, and improve health

e. Be proportionate and cost-effective.

22. You also identified responsiveness to government priorities as an important design principle.

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23. We have used that set of principles as the basis of the following refined principles for consultation:

Health workforce regulation should:

- **Support and align to overall health system objectives;**
- **Support safe innovation in practice and models of care;**
- **Be informed by professional identities and knowledge;**
- **Support the health system to protect, promote, and improve health**; and
- **Be proportionate and cost-effective.**

Are you comfortable consulting on these design principles? Yes ☐ No ☐

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Governance framework

24. You have agreed that legislation will provide for a **governance framework** that strikes a balance between profession-led regulation and government oversight. The key features of the framework would be:

    a. a mechanism to provide **all-of-system strategic direction** to regulators, so that they advance broader health system priorities through their regulatory remit

    b. embedding **cross-profession cohesion, decision-making, and implementation of the strategic direction**

    c. allow some form of intermediate **intervention** where performance is inadequate

    d. appropriate **monitoring and reporting mechanisms**, to ensure accountability.

All-of-system strategic alignment

25. Establishing a mechanism for strategic alignment will allow us to ensure that health workforce regulation, planning and development, and education settings align with and support the expectations of Ministers. There is a spectrum of mechanisms to achieve alignment from less to more directive.

26. We consider consultation should cover the following options:

Option	Comment
A general requirement for authorities **to have regard** to government health workforce policy when making regulatory decisions	This would provide a base level requirement for the authorities to think about wider system needs. It would not impose any actual obligation to do anything in response to them.
A requirement for authorities **to have regard** to the Government Policy Statement on Health	This would enable expectations to be set out. Have regard means authorities would need to show they had thought about the expectations, but would not mean they had to follow them.

A requirement for authorities **to give effect to** the Government Policy Statement on Health	This is a stronger mechanism that would require the authorities to meet the expectations in the Government Policy Statement.
A requirement for authorities **to follow** guidance issued by the Minister	This is a strong mechanism. It would enable more detailed guidance to be set than by using the Government Policy Statement, as directions would be solely about workforce.
A power for the Minister **to direct** responsible authorities on regulatory issues	This would enable you to set out exactly what the authorities must do. It would need to have an exception for employment matters or individual cases, to avoid any perception of impropriety.
Recommendation: We recommend consulting on all these options. Our preference would be to have the full range of powers available in legislation, so they could be used if required.	**Are you comfortable consulting on these direction options? Yes ☐ No ☐**

Cohesion of regulatory system

27. The directive powers above will provide for a level of strategic alignment across the regulatory system. We also consider a cohesive regulatory system needs the responsible authorities to work together on an operational level in a way they do not at present. Again, there is a spectrum of options from less to more directive.

28. We seek to consult on the following options:

Option	Comment
Provide that it is a function of authorities to cooperate when undertaking functions.	This would be a change from the current function to liaise on matters of common interest. This option is a comparatively weak obligation that does not ensure any particular level of effort.
Require authorities to cooperate when carrying out their functions	This is a slightly stronger obligation as it sets out *how* authorities must carry out their functions, rather than merely making one of their functions to cooperate.
A power for the Minister to direct authorities to jointly agree decisions	This is a stronger power that would allow you to direct joint decision-making on particular issues. For example, you could direct a joint decision on standardising prescribing practices. It likely would work best if the legislation also allowed you to direct them on regulatory decisions if a joint decision could not be reached.
Require authorities to follow guidance from the Minister on functions	This would allow you to issue general guidance that the authorities would have to follow. This would allow the level of detail to be tailored to the

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	circumstances, without having to single out any authority. Authorities would still have discretion in precisely how they responded to guidance.
Power for the Minister to issue general direction on functions	This would require the authorities to do something specific or in a specified way. For example, it could allow you to require them to establish shared support functions, or to coordinate accreditation of training facilities, or to follow a particular process to determine someone's fitness to practise.
Recommendation: We recommend consulting on all these options. This is largely to gauge reactions. Our preference would be to have the full range of powers available in legislation, so they could be used if required.	**Are you comfortable consulting on these direction options? Yes ☐ No ☐**

Monitoring and reporting mechanisms

29. Monitoring and reporting mechanisms are very weak in current legislation. That means we have limited knowledge of the functioning of the system. Better information is required to facilitate workforce planning and early identification of, and response to, issues. There is a standard set of powers to get information and to require particular forms of reporting, which we consider should be applied to the authorities.

30. We seek to consult on the following options:

Options		**Comment**
Provision	Requirement for specified performance information to be provided from all responsible authorities	This would mean authorities had to provide information, which would be specified in a notice, or similar instrument. It would allow us to routinely get similar information from authorities, allowing comparisons. Information would need to be specified in a public document, meaning we couldn't use it to get information in response to an emerging issue.
	Ministerial power to require information from responsible authorities, without limits of current power	This would allow any information to be obtained, at any time. This would be more flexible and powerful than the current power, which does not require authorities to give information they don't have already, and which requires the costs (if any) to be met from Crown funding. This is similar to the powers you have with respect to Crown entities.
Publication	Provisions requiring performance information in annual report	This would mean legislation requires authorities to report on their performance of their functions. This is similar to the requirement on Crown entities to report performance against their statements of

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		intent. There would be some flexibility in the form of the information.
	Ministerial power to direct inclusion of information in annual report	This would allow you to direct that information about performance be included in an annual report. This would allow the form to be specified, allowing for comparison across authorities.
Recommendation: We recommend consulting on the full range of options. Our preferred option would be to have all these tools available.		**Are you comfortable consulting on these monitoring options? Yes ☐ No ☐**

Intervention powers

31. Intervention follows a continuum from statements to dismissing authority members or disestablishing organisations. Current intervention powers are largely limited to the extreme ends of that continuum:

    a. auditing and requesting improvements (which the authorities are not obliged to make)

    b. directing a resolution to a dispute between authorities about overlapping scopes of practice; and

    c. dismissing board members if the Minister is satisfied about their incapability, neglect, or misconduct.

32. You have agreed to explore more nuanced intervention powers, allowing more proportionate and immediate action to be taken to address issues.

33. We seek to consult on the following options:

Options		**Comment**
Intervention on decisions	Require reconsideration of decisions	This is a light-touch option. It would allow you to make an authority reconsider a scope of practice change, for example. It would not require them to make a different decision. The main benefit of this power is that authorities would have a strong incentive to make careful decisions. It would preserve independence of authorities.
	Require independent review of decisions	This is a relatively light-touch option, which would allow you to make an authority refer a decision to another person or organisation for review. This would encourage careful decision-making and allow for external perspectives, which might not otherwise be readily available, depending on the make-up of the authorities.
	Direct particular content (of scopes of practice, etc)	This would allow you to effectively make the decision for a regulator. This is a very strong power,

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		which would potentially be seen as undercutting regulatory independence. The advantage of this power is that it would allow effective intervention if authorities engage in patch protection or similar.
Intervention on performance	Require an improvement plan	This is the same power you have with Health New Zealand. An authority would be required to publicly state how they will improve performance.
	Require particular action	This would allow you to require a particular action to improve performance. The advantage would be it could be used to precisely address issues. The disadvantage is that you may carry risk for any adverse effects of the actions you direct.
	Install Crown observer	This would allow you to put a Crown observer into an authority, who could get information, attend meetings, etc. This is a useful tool for addressing dysfunctional organisations. It might be seen as undercutting independence.
	Replace authority with commissioner	This would only be an emergency power in the event of extreme dysfunction. You could immediately dismiss an authority and have a commissioner undertake the necessary functions, while new appointments were made.
Recommendation: We recommend consulting on all these options. While some of them would be rarely, if ever, used, they are all potentially useful. There should be an exception ruling out ministerial direction in individual cases, which will preserve the authorities' independence.		**Are you comfortable consulting on these options for intervention powers? Yes ☐ No ☐**

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Further options to improve regulation

34. The above series of decisions provide the basic machinery we consider is necessary to begin shifting workforce regulation to support the Government's overall workforce strategy. In particular, the addition of direction mechanisms will enable for the first time the Government to require overall system needs to be considered.

35. By themselves, those changes may promote improvement. The precise results will depend on exactly what directions are made, how the monitoring and intervention powers are used, and how the regulators respond to them.

36. There are further changes that could better support a responsive, cohesive, and collaborative workforce regulatory system that supports overall workforce goals. We seek to consult on options for public input into the regulatory system, and more

proportionate regulatory options (rather than just regulated or not as with the current system).

Public input

37. It is a core part of the health system that the public should have a say in the services available to them. At present, workforce regulatory decisions may be made with no public input. Authorities are required to consult professional representative groups, but there is no requirement for public consultation. Similarly, there is little public input into the operation of the authorities.

38. We seek to consult on the following options:

Option	Comment
Requirement to consult publicly on scopes of practice and qualification requirements	This would allow the public, members of other professions, and service providers to comment on scopes of practice and qualifications.
Even numbers of lay and practitioner members of authorities	This would be a significant change for health, where practitioners have always dominated the regulatory authorities. It would allow a wider range of expertise, and ensure public sentiment was considered in decisions.
Recommendation: We recommend consulting on these options. Our preference would be that both changes are made.	**Are you comfortable consulting on these options for greater public input into health workforce regulation? Yes ☐ No ☐**

Proportionate regulation

39. At present, there are no intermediate options in health workforce legislation. Professions are either regulated, or not. s 9(2)(g)(i)
s 9(2)(g)(i)
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40. There is a continuum of options for professional regulation:

  a. **Negative licensing**, where there are no regulatory requirements to practise an occupation, but someone can be prohibited from carrying out the occupation under certain circumstances. This is suitable for activities where the risk of harm is low, or it can be easily remedied, and where users have a realistic choice and can be expected to judge competence.

  b. **Disclosure**, where a practitioner is required to disclose specified information about their qualifications and practice. This is a common feature of financial regulatory schemes, for example banks must disclose a range of information about their financial position.

  c. **Simple registration**, where a practitioner must register with an authority, but there are no required qualifications. This is for activities with a low risk of harm to individuals, but where follow-up may be required. As an example, hairdressers must

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register with the appropriate local authority, but do not have to demonstrate competence.

d. **Certification**, where an authority can certify that particular people have demonstrated their competence in a field. This may then be relied on by the public as a reasonable guide to competence. These schemes generally include means to remove certification where a person does not meet the required standards. For example, Maritime New Zealand issues certificates to seafarers, assuring their competence for particular duties.

e. **Accreditation and registration**, which is a mix of certification and registration. Organisations can be accredited to set standards for a profession and to register practitioners. Registration is voluntary but has benefits in providing a clear signal of competence to prospective employers and patients. Someone can be deregistered or face other sanctions if they do not uphold standards.

f. **Licensing of tasks** may be used where there are specific activities that are especially risky. It can be stand alone or part of broader regulation. For example, only specified practitioners can prescribe medicines, and only registered (ie, licensed) practitioners may be specified. It can also cover particular activities in occupations where we otherwise do not require licensing, for example the licensing of building practitioners to carry out moisture protection work.

g. **Licensing of practitioners** is the most restrictive means of regulating an occupation. This is essentially how we regulate health professions. No one may practise as members of professions that require licensing unless they are registered with the appropriate authority and meet ongoing competency requirements (in health, usually through obtaining an annual practising certificate). This is appropriate for the most high-risk occupations, where incompetent practice poses serious risks that the public cannot meaningfully judge.

41. We seek to consult on a spectrum of new regulatory mechanisms to allow for professions and activities to be regulated in the least restrictive way that is compatible with public safety. While public safety is the primary reason for regulating – we should not regulate if there is no risk – there are ancillary benefits. Regulation is often sought by professions as a means of assuring their customers, the public and institutional funders alike, that they are reliable and safe.

42. We seek to consult on three intermediate regulatory options:

Option	Comment
Simple registration	This would mean someone has to simply notify a regulator they intend to practise a profession, but does not need to demonstrate competence. It is suitable for low-risk activities, that might nonetheless require follow-up. This is how hairdressers are regulated, for example.
Certification	This would mean someone could only practise a profession after achieving the appropriate qualification, or standard of performance for on-the

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	job-learning. This could be a mechanism for increasing the number of vaccinators, for example.
Accreditation	This would mean an authority accredited another body to carry out quasi-regulatory functions. s 9(2)(g)(i)
Recommendation: We recommend consulting on these three options. We do not consider other options are likely to be useful. Our preference would be for the broadest range of regulatory options to be available, to ensure flexible and proportionate approaches can be taken.	**Are you comfortable consulting on these options for proportionate regulation?** **Yes ☐ No ☐**

High quality regulation

43. Since 2003, drafting practice has changed, and responsible authorities and the Ministry have had 20 years of experience of the HPCA Act in practice. The discussion document will be an opportunity for responsible authorities in particular, but also the public and other stakeholders, to raise concerns that can be addressed when we come to draft legislation. For example, the current Act provides that appointments to the disciplinary tribunal expire after five years. This has been a problem in the past, when appointments have been delayed. The standard provision for government appointments is that they continue past expiry until new appointments are made.

44. We propose to consult in very general terms on improvements to regulatory machinery. This will provide an opportunity for people to make comments about any aspect of the legislation, which we can then incorporate into the drafting of new legislation. We do not propose to consult in detail on any general drafting improvements. There will be the opportunity with select committee consideration for people to comment on the detail of changes.

45. We seek general feedback on improvements to the legislation:

Because the Health Practitioners Competence Assurance Act 2003 is 20 years old, many people have experience of where it is not working well and could be improved. Do you have any suggestions for improvements to the legislation? **Are you comfortable consulting in these terms? Yes ☐ No ☐**

Sustainable and efficient regulation

46. Regulators vary hugely in resources and capability. Because they are funded by the professions, there are equity issues for some lower paid and smaller professions. While there would potentially be a case for some government funding, given the benefit to the

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public, there are very easily attributable private benefits to health workforce regulation that we consider it should still be cost-recovered from the professions.

47. The solution to financial sustainability of the smaller regulators is therefore to be found in joint work and sharing resources. That could be shared services, which could include sharing regulatory effort. It could also mean amalgamation of some authorities. Shared services can be encouraged or directed using the powers proposed above.

48. There is already a regulation-making power to amalgamate authorities following appropriate consultation, so no legislative change is required. Consultation must be with the affected professions on a reasonably detailed proposal. At this stage, we do not have clear proposals or criteria for amalgamation of authorities.

49. We think it would be worthwhile to ask in the discussion document for views on possible criteria for amalgamation of authorities:

Option	**Comment**
Minimum annual revenue	As financial sustainability is the main issue prompting potential amalgamation, it makes sense to consider a minimum viable organisation criterion. We do not have a view on what the minimum annual revenue would be. Current authority annual revenue ranges from about $20 million, to about $450 thousand.
Similarity of professional activity	The more similar a profession is to another, the more sense it appears to make to have them regulated by the same authority. We would seek comment on how we might gauge similarity.
Complexity of regulation	This criterion is about the amount of work an authority does. An authority with complex scopes of practice that deals with many complaints might not be a good candidate for amalgamation, while one with simple scopes and few complaints might be.
Recommendation: We do not have a view on the appropriate criteria. It will be useful to get external views on what they might be.	**Are you comfortable consulting on these options for criteria for amalgamating authorities? Yes ☐ No ☐**

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Structural options

50. There are structural change options that could reinforce and provide additional assurance of meeting the government's objectives. While new functions and powers to coordinate could sit with the Ministry, there are two broad structural options for reform. A new entity overseeing the existing regulatory authorities ("hub and spoke") could provide a critical mass of expertise, with a greater degree of independence from the professions, while retaining the profession-specific authorities. It would also be possible to amalgamate all the authorities into a single entity. This would offer consistency across professions, and easily share resources and functions.

51. While structural change is not the focus of the discussion document, we consider it would be worth consulting on the following options:

Option	**Comment**
Oversight entity	This would be a new organisation. It would have powers of direction and review. The advantages of such a body would be that it could intervene directly and routinely in regulatory decisions, which it is not appropriate for the Minister or Ministry to do. It would be able to identify gaps in regulation (such as physician associates) and facilitate coordination between authorities. It would mitigate the patch protection effects of profession-based regulation, while retaining professional identity at the heart of the system. We would propose funding it via a levy on the regulatory bodies.
Single regulator	This would be a single regulator undertaking all functions of the current authorities. The advantages of this option are that it is the simplest once implemented. It would be a single, consistent regulator, with benefits for both the public and employers. It offers reduced coordination costs and reduced patch protection effects. It would be straightforward for this entity to identify new professional scopes and easy to have scopes overlapping professional boundaries. A single entity would provide a single point of influence for the Minister and Ministry. However, it would also be a single point of influence for the professions, and would pose a challenge for the Ministry to engage with and manage. The implementation cost and time would be significant. It is not clear that the single entity option offers enough increased benefit over the oversight entity model to warrant such a significant change. The change processes would also likely interfere with the workforce reform the Government is currently seeking.
Recommendation: We consider it is worth consulting on broad structural options, to inform further policy development and advice.	**The changes discussed above should be sufficient to shift the workforce regulatory system to achieve the Government's goals. However, if they do not, structural change may be required. We seek your views on two possible options.**

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	Are you comfortable with the Ministry consulting on structural options in these terms? Yes ☐ No ☐

Next steps

52. The Ministry will provide you with the following material for you on 12 December 2024:

    a. Draft discussion document

    b. Draft Cabinet paper seeking approval for consultation.

53. We will provide final versions for you to take to Cabinet in early 2025 seeking agreement to release the discussion document in February 2025.

s 9(2)(f)(iv)

54.

55.

ENDS.

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Appendix: Parts of the HPCA Act

s 9(2)(f)(iv)

Part	Provisions
1 (Preliminary and key provisions)	• Purpose • Definitions of terms • Unqualified people must not claim to be health practitioners • Health practitioners must practise within their scope • Certain activities can be restricted
2 (Registration of, and practising certificates for, health practitioners)	• Authorities must specify scopes • Registration of health practitioners • Annual practising certificates
3 (Competence, fitness to practise, and quality assurance)	• Mechanisms for improving the competence of health practitioners • Mechanisms for protecting the public from health practitioners who do not meet competence requirements • Quality assurance activities
4 (Complaints and discipline)	• Complaints about health practitioners • Authorities can take interim action • Professional conduct committees • Health Practitioners Disciplinary Tribunal
5 (Appeals)	• Appeals against decisions of authorities

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		s 9(2)(f)(iv)
	• Appeals against decisions of the HPDT	
6 (Structures and administration)	• Establishes authorities • Amalgamation of authorities • Functions of authorities • Minister's powers • Requirement to keep public register • Financial matters	
7 (Miscellaneous provisions, consequential amendments and repeals, and transitional provisions)	• Service of documents • Naming policies • References to health practitioners in other enactments	

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