Submission on the Health Practitioners Competence Assurance Act 2003

1. This is a joint submission on behalf of 11 of the 18 responsible authorities (together the **Collective of Health Responsible Authorities** as listed in Appendix 1) created under the Health Practitioners Competence Assurance Act 2003 (**HPCA Act**). We appreciate and welcome the opportunity to provide our collective view on the HPCA Act and, in particular, parts 1, 2, 3, 6 and schedule 3.[1]

2. We repeat the limitations to this submission that were set out in the response dated 6 November 2024 on the Disciplinary System under the Health Practitioners Competence Assurance Act 2003 (the **Disciplinary Submission**) – specifically, that given the timeframe for responding we have not been able to engage with all relevant stakeholders or the members of the professions we regulate on the matters that form part of this submission. Further, without clear problem statements and/or an outline of proposed reforms from the Ministry, it is difficult to provide targeted and relevant input.

3. Going forward, if the intention is to significantly amend, or even replace, the HPCA Act, we would appreciate more time and information to provide effective contributions and responses. Additionally, we seek a transparent process and further dialogue with the Ministry on the policy and legislative approach that is being considered.

General comments

4. Our overall opinion on the HPCA Act, as set out in the Disciplinary Submission, remains the same – the legislation is robust and is effective in ensuring public safety. With the exception of the matters set out below, the regulatory model remains fit-for-purpose and its underlying principles – particularly protection of public health and safety (s 3) – are still relevant. The HPCA Act reflects a right touch approach to regulation that ensures patient safety by providing for well-established and robust mechanisms to ensure professionals are qualified, fit, and competent to practise.

5. We support the HPCA Act remaining in force but acknowledge that amendments could be made to improve and refine the regulatory model. Our view is that there is no need to significantly overhaul the regulation of health professionals in New Zealand (e.g. enact new legislation with a new model) or “lift and shift” any of the powers of the RAs over to other organisations.

6. In particular, the 18 individual RAs are well-placed to oversee the separate regulated health professions in New Zealand. Separate RAs allows for flexible regulation that is responsive to shifts in the health system and ensures customised oversight and accountability of the different health professions. Critically, also, the current model allows each of the RAs to set specific standards for the health practitioners they regulate. This, in turn, ensures that the standards for each profession can be precisely tailored for that profession, including in relation to addressing any inherent risk to the public from the practise of the profession.

7. It is important to note here, that amalgamating RAs or shifting RAs to a Crown Entity model may incur significant government costs, including increasing government contributions to operating costs; ensuring organisations are equipped to comply with legislation that applies to Crown Entities such as the Official Information Act 1982

[1] Specifically, this submission responds to the request for views contained in the email from Ben Clayton (Ministry of Health) dated 19 February 2025.

(RAs are not currently subject to this statute and so do not have this cost burden); and developing appropriate IT systems with capability to manage highly sensitive health information. While we can appreciate the benefits of standardisation, we think it is essential to preserve the unique characteristics, values, and professional standards of each health profession. The individual identity of each health profession should be maintained, while at the same time ensuring collaboration between the RAs for the benefit of the public.

8. We acknowledge the importance of maintaining a competent, consistent, and healthy workforce in New Zealand's health system. This requires regulators to collect workforce data and monitor workforce numbers and capabilities. We understand the need for RAs to be transparent with this information to the Ministry and pro-active in using regulatory levers to maintain stable workforce numbers and capabilities where possible (e.g. expediting pathways for safe and competent overseas practitioners). We discuss this further below.

9. We also acknowledge the benefits of performance reviews for RA (ss 122A-122B). This allows the Ministry to determine the effectiveness and efficiency of individual RAs. The reviews result in recommendations, which, in turn, ensure improvements in the oversight and regulation of health practitioners. Among other things, a performance review may identify if there is any particular need for the amalgamation of two or more RAs (s 116A – s116D). We endorse this process as a targeted pathway to ensuring efficiency, as opposed to global amalgamation of all the powers and functions of the RAs.

10. Our view is that considerable stakeholder and public engagement and consultation is necessary before the Ministry proposes any major reform to the regulation of the health professions. The outcome of that engagement and consultation will, in turn, need to justify and support any major changes. There needs to be clear evidence of potential improvements to the current, robust regulatory model to justify the significant disruption to the workforce and cost burden to the public that would result from major reform. We emphasise the need to carefully consider (and account for) any new cost burdens that may fall on RAs, and in turn, the practitioners they regulate, arising from reforms to the legislation.

Part 1

Section 7

11. Currently it is the responsibility of the Ministry to take action on an alleged breach of s 7. However, often an RA will notify the Ministry of any alleged offending. We are concerned about the Ministry's enforcement of this section – particularly around timeliness of any response from the Ministry and a perceived reluctance to prosecute.

12. The RAs could be given authority to investigate and prosecute individuals who breach s 7. This would be consistent with the role of the RAs to protect the titles of registered practitioners. It is recognised, however, that this would be a significant additional function for RAs, and it may be that the Ministry remains best placed with its standing legal team to continue to have responsibility for prosecutions under s 7. Another option may be for RAs to investigate and then provide the Ministry with the investigation report, including a recommendation about prosecution, for the Ministry to consider and action. Sharing the burden in this way may help to promote increased enforcement of this provision.

13. The level of fine for a breach of s 7 has not been changed since the HPCA was first enacted - $10,000. This section could be strengthened by an increase in the maximum level of fine that may be imposed.

Sections 11(2), 21, 22

14. While the scope of practice regime generally works well, we think that greater flexibility could be built into the regime to allow RAs to extend an individual practitioner's scope in appropriate cases. This could be done by clarifying at s 21 that an authorisation may be in the form of an extension to the services that a practitioner is able to provide in their current scope. This has the benefit of expanding the range of health services that some practitioners (e.g. rural practitioner) can provide to the public if it is safe and appropriate for them to do so.

Part 2

Section 16

15. We suggest that one of the reasons included in the list at s 16 for refusing registration is if the applicant has been convicted of an offence under the Armed Forces Discipline Act 1971. A history of military misconduct may indicate that the applicant is not fit and competent for registration.

16. The RAs recognise that Te Reo Māori and New Zealand Sign Language (NZSL) are official languages. There may be situations, for example, where a person does not meet English language requirements but is able to communicate in NZSL. They may be a valuable asset to the deaf community as a registered health practitioner. Sections 16(a) and (b) could be amended to recognise all three official languages.

17. Subsections (e) to (g) require that the applicant *is currently* subject to proceedings or an investigation or an order. This excludes the possibility of previous investigations/proceedings/orders being considered as part of the fitness for registration requirements. It is suggested that the wording is changed to "*is or has been...*".

18. It is suggested that a further catch-all is included at the end of s 16 to capture conduct that may not reach the threshold for endangering the health and safety of the public (s 16(h)) but none-the-less raises questions about a practitioner's fitness for registration (e.g. concerns about dishonesty during the applicant's training). The provision could state:

> The responsible authority is not satisfied that the applicant is a fit and proper person to be registered.

Sections 18 and 19

19. We think that s 18 could include a further subsection to clarify that RAs do not need to automatically re-register a practitioner following fulfilment of s 102 conditions imposed by the Heath Practitioners Disciplinary Tribunal (the **Tribunal**). This will help to avoid arguments from individuals that they should be re-registered even though the RA has information that they still present an ongoing risk to the public.

20. We think that s 19 should include a subsection expressly allowing RAs to receive information from Professional Conduct Committees (**PCCs**) in respect of practitioners

who are applying for re-registration after their registration has been cancelled by the Tribunal. Although s 19(2) allows RAs to receive any information "*if it thinks fit"* from "*any other person",* RAs have previously been challenged for considering information from PCCs. We suggest the following amendment:

> (2A) The authority may, if it thinks fit, receive any information from a Professional Conduct Committee involved in the prosecution of a charge before the Health Practitioners Disciplinary Tribunal in respect of the applicant.

Section 34

21. We recommend amending s 34(1) to make it a mandatory requirement for a health practitioner to notify the Registrar where they have reason to believe that another health practitioner may pose a risk of harm to the public. This is because health practitioners have a professional and ethical duty to protect patients, which is consistent with a mandatory obligation to report concerns about incompetent or unsafe colleagues. Health practitioners are often best placed to identify and describe concerns about colleagues and mandatory notification will allow for early intervention and management by the RAs.

22. Section 34(3) should be extended so that employers must give notice to the Registrar if an employee is dismissed or resigned for reasons relating to conduct, as well as competence. Concerns about conduct may pose the same or a greater risk to the public that competence concerns.

23. Finally, we also think that s 34 should include an express discretion for employers to notify the Registrar if a practitioner has resigned or been dismissed because of health concerns. This should not be mandatory because there may be valid reasons why the practitioner resigned due to their health that is unrelated to any risk to the public. However, including an express discretion in s 34 will provide the employer with the protection under s 34(4) in relation to the disclosure and particularly around disclosure of any sensitive health information.

Section 35

24. There may be situations where it is not appropriate for an RA to notify the agencies listed at s 35(1), for example where a notification is too punitive, or the risk of harm is low. In other cases, it may be appropriate to notify other agencies instead of those listed at 35(1) – e.g. where a practitioner has a contract with a PHO.

25. Therefore, it is suggested that s 35 is amended to give RAs discretion about:

    a. whether or not to notify agencies if there is a risk of harm posed by the practitioner's practice; and

    b. what agencies ought to be notified.

26. In addition, the Ministry may consider amending the threshold to be "risk of *serious* harm". This will help to achieve the right balance between a practitioner's right not to have their reputation unduly tarnished before the final outcome of any investigatory/disciplinary process and ensuring the safety of the public from any serious harm.

27. Further to this point, it is noted that s 35(1) may be triggered before an RA has completed its inquiries – i.e. the RA may receive information that gives rise to reasonable belief that there is risk of harm to the public before the investigation is

complete. Therefore, requiring RAs to carry out inquiries before making a notification may not fix the problem that a notification may unfairly tarnish a practitioner's reputation, especially if the risk of harm is low-level.

Section 36

28. We suggest that the grounds under s 36(2) be expanded to allow for RAs to take steps in response to competence concerns from any source and not just referrals from PCCs or s 34 notifications. It is acknowledged that s 36(4) allows for the RAs to review the competence of a practitioner at any time; however, we believe that amending s 36(2) will make it clear that RAs can review a practitioner's competence on the basis of information from any source. This approach is consistent with s 68 and the RAs' wide power to refer to a PCC provided it has "*information in its possession [that] raises 1 or more questions about the appropriateness of the conduct or the safety"* of a practitioner.

29. Accordingly, it is suggested that s 36(2) includes a further subsection (c) that reads:

> (c) a notice of concern, or information that raises concerns, from any organisation, agency or person who has reason to believe that a health practitioner may pose a risk of harm to the public by practising below the required standard of competence.

Section 40

30. The options under s 40(3) are too restrictive and should include a catch-all – e.g. "*complete or undertake any other step that the responsible authority deems necessary to ensure the practitioner meets the required standard of competence"*. This will ensure that the competence programme is tailored to fit the practitioner's individual requirements which will, in turn, help to ensure the practitioner is competent and safe.

Section 45

31. This section does not currently provide for situations where a practitioner resigns because of a health issue but does not intend to continue practising. There are often cases where RAs receive notice under s 45 about practitioners who do not intend to continue practising but s 47 requires that the RA takes at least some steps in relation to the notification. This may risk causing further harm to a practitioner who is already unwell (perhaps even terminally unwell) and is unnecessary if the practitioner does not intend to continue practising. We suggest that this provision includes greater discretion for employers to notify about health issues if there is a clear intention, or inability, for the practitioner to continue practising.

Section 48

32. The 20-working day (+ 20 working day extension) timeframe for RAs to suspend a practitioner or alter their scope of practice is not sufficient in some cases for RAs to put in place measures to address health concerns. It is suggested that this provision is amended to allow for RAs to indefinitely extend the period for 20 working days at a time if it is reasonable and necessary to manage ongoing health concerns.

Sections 49 and 50

33. It is submitted that s 50 powers shouldn't be dependent on a s 49 notice being given first. In some cases, a practitioner may volunteer to be subject to s 50 powers or the information obtained by the RA may be so compelling that a s 50 order is required without the need for an examination or testing under s 49. Accordingly, it is suggested that s 50(1)(a) is amended to include the alternative that the responsible authority has reason to believe that the mental or physical health of an individual poses a risk of serious harm to the public. This amendment includes the threshold of "*risk of serious harm"* so that it will only be in rare cases that a responsible authority will make an order under s 50 without first going through the s 49 process.

Part 6

Section 118

34. The RAs have year after year proven themselves able to efficiently and successfully fulfil the functions set out at s 118. We say that this achievement, itself, is proof that a significant change to the current regulatory model is not required. Certainly, we do not think there should be a narrowing or "lift and shift" of any of the functions listed at s 118. The functions allow each RA to take a 360-degree approach to ensuring safe and competent practise by health practitioners - from registration to education to discipline to rehabilitation.

35. We note that the RAs whole-heartedly support the most recent addition to the list at s 118 – "(*ja) to promote and facilitate inter-disciplinary collaboration and co-operation"*. Members of our Collective are regularly finding opportunities for collaboration, which create efficiencies and more cohesion and co-operation among different health practitioners within the health system. One example is this very submission, where we have come together as a unified voice. Another example is the joint workstream developing an all-RA Statement of Intent on Interprofessional Collaborative Practice and an education programme to support this. Indeed, we have identified that the best opportunity to embed co-operation between professions is at the undergraduate level and we are currently working together on how to target this area.

Section 120

36. Laypersons are important voices for the consumer/public perspective. We think that the number of laypersons sitting on an RA should not be restricted provided that the majority of members are still registered members of the profession (to ensure the RA has necessary expertise and knowledge of the profession). Therefore, we suggest that s 120(2)(b) and (c) are amended to state "*at least 2 laypersons..."* and "*at least 3 laypersons"* respectively.

Section 122

37. We suggest that s 122(4) is expanded on to allow for a member to be removed from office if the member is not considered to be fit and proper to continue in the role. This would give RAs more discretion to ensure its members are able to efficiently and effectively fulfil their functions without being adversely impacted by a rogue member. Section 122(3) could be amended to state:

> A member of an authority may be removed from office by the Minister, with the concurrence of the authority, by notice given to the member, on the ground that:
>
> (a) The member's performance on the authority is inadequate; and/or

(b) The Minister has reason to believe that the member is no longer a fit and proper person to continue to be a member of the authority.

Section 134A

38. We suggest that the references to "*Director-General of Health"* is changed to "*Office of the Director-General of Health"*.

Section 138

39. Although RAs can publish the names of practitioners who have had their registration cancelled pursuant to their Naming Policy, we suggest that s 138 is amended to require that RAs include as part of the register the names of practitioners who have had their registration cancelled, the reason for the cancellation and the date of cancellation. This will promote transparency, accountability and public safety by publicising information about all cancelled practitioners.

40. We note that the Australian Health Practitioners Regulation Agency (Ahpra) publishes both a list of cancelled, disqualified and/or prohibited practitioners, and a list of practitioners who have agreed not to practise as a result of regulatory action. We also note that s 138(3) of the HPCA Act already requires that a suspension is recorded on the register, presumably to protect public safety by providing information relevant to the patient's choice of practitioner. Equally, we think a patient will want to know if a person they have received treatment from, or may seek treatment from in the future, is cancelled.

41. Section 138 could be amended by including a new subsection 3A as follows:

> Each authority must maintain and publish a list of all health practitioners who have previously been registered by that authority and who have had their registration cancelled, including the reason for cancellation and the date of cancellation.

42. In the same vein of transparency, the register could include a link to any decisions of the Tribunal about a practitioner (except if the practitioner has been granted name suppression). Again, this would promote informed decision-making, public safety and transparency.

Section 144

43. We think that this provision could be modernised and made more effective by removing the references to writing/sending a letter to the practitioner. Instead, it could say the "*Registrar must write to the practitioner, by e-mail and/or post, at their last known address(es) for service".* Subsection 144(4) would also need to be amended to say: "*If the Registrar does not receive a reply to the correspondence sent under s 144(2) after 6 months after it was sent, the Registrar may give the health practitioner notice in writing to his last known e-mail and/or postal address that the entry in the register...".*

44. We also think the option could be explored under this provision to automatically commence the cancellation process if a practitioner does not renew their APC or advise that they want to be non-practising for a period. This ensures better transparency about practising intentions and, in turn, workforce capabilities.

Section 145

45. This section could include the ability to restore registration if it has been cancelled under s 142 (currently it only relates to cancellation under ss 143 and 144). It seems unnecessary to have different pathways under the legislation for re-registering depending on how registration was cancelled in the first place.

Schedule 3

Clause 3

46. We suggest that the option is explored of RAs having the ability to appoint a co-Chairperson instead of or in addition to a deputy chairperson. This may allow for more representation from different backgrounds at the leadership level and greater availability of the Chair at times when urgent decision-making is required.

Other comments

Health workforce monitoring and management

47. Our view is that the HPCA Act could be amended to ensure RAs monitor workforce data; that they are transparent with this data; and that they can respond to negative changes in workforce data with regulatory levers. We think the RAs are best placed to take on this responsibility with accountability to the Minister.

48. We understand that the Social Workers Registration Board has an annual workstream dedicated to workforce planning for all social workers in New Zealand. This enables it to understand and report on the issues, opportunities and challenges faced by the social worker workforce. In turn, the Board can explore ways to ensure the sustainability of the workforce. Information relevant to workforce planning is collated from registration information as well as an annual survey of registered social workers. This is then collated into the Annual Social Worker Workforce Report.

49. We think the HPCA Act could be amended to include a section(s) that requires RAs to prepare a similar annual workforce report to be presented to the Ministry. This will give the Ministry regular visibility of any challenges in the workforce and ensure RAs and/or the Ministry can move quickly to address any concerning trends. We add that RAs are the best placed to collate and interpret the data required to prepare such a report.

Unregulated health professionals

50. The HPCA Act does not capture all workers working in the health system. This is because regulation is expensive and any cost that is imposed on individuals ought to be justified as necessary to manage any potential risk to the public. Unregulated health workers are still, however, required to comply with all relevant laws, employment agreements, Consumer Code of Rights, Health Information Privacy Code etc. Therefore, we recommend the Ministry proceeds with caution before implementing legislation that captures both regulated and unregulated health professionals. Such legislation may be unduly complex and impose an unnecessary regulatory and cost burden on some workers and the health system as a whole.

Gendered terminology

51. Currently the HPCA Act uses gendered terminology – i.e. “his or her” or “he or she”. It is suggested that this be changed to a consistent use of gender-neutral terms, such as “their” or “they”.

Appendix 1 – membership of Collective of Health Responsible Authorities

1. Te Poari Tiaki Waewae o Aotearoa | Podiatrists Board of New Zealand
2. Chinese Medicine Council
3. Kaunihera Manapou | Paramedic Council
4. Te Poari Whakaora Ngangahau o Aotearoa | Occupational Therapy Board of New Zealand
5. Te Tatau o te Whare Kahu | Midwifery Council
6. Te Kaunihera Pūtaiao Hauora O Aotearoa | Medical Sciences Council
7. Te Poari Ringa Hangarau Iraruke | Medical Radiation Technologists Board
8. Te Poari Kaikorohiti o Aotearoa | Chiropractic Board
9. Te Poari o ngā Kaihaumanu Hinengaro o Aotearoa |The Psychotherapists Board of Aotearoa New Zealand
10. Te Poari Kaimātai Hinengaro o Aotearoa | New Zealand Psychologists Board
11. Te Poari o ngā Kaimātai Whatu me ngā Kaiwhakarato Mōhiti | Optometrists and Dispensing Opticians Board