

MEMORANDUM TO CABINET COMMITTEE ON EDUCATION AND HEALTH

HEALTH PROFESSIONALS' COMPETENCY ASSURANCE BILL

PROPOSAL

1. It is proposed that the Health Professionals' Competency Assurance Bill (HPCA) replace the current eleven health occupational regulatory statutes.

EXECUTIVE SUMMARY

2. Most of the current statutes are old, prescriptive and are unable to accommodate changes in technology and health professional roles in a changing health sector. They do not meet the needs of the public, the regulators or the professions. The proposed legislation will provide a framework to give registering authorities more flexibility in their registration processes, but, at the same time, include adequate controls to ensure that they cannot operate restrictive practices.
3. The principal purpose of the HPCA is to protect the health and safety of the public by establishing processes to ensure that regulated health professionals are competent to practise.
4. The proposed Bill would:
 - establish the framework for the regulation of health professionals where there is a risk of harm to the public
 - establish registering authorities for each profession
 - empower the Minister of Health to appoint members of registering authorities and audit their processes to minimise their ability to operate restrictive practices
 - establish the functions of registering authorities
 - empower registering authorities to:
 - i) assess the qualifications and experience of practitioners and register them in an appropriate scope of practice
 - ii) review the ongoing competence of practitioners and require them to participate in competence improvement programmes if necessary

- iii) certify that practitioners are competent to practice
 - iv) suspend practitioners if there is a risk of harm to the public
- include a list of licensed tasks which can be practised only by practitioners who are certified as being qualified and competent to do so
 - provide for declared quality assurance activities to improve the practice or competence of health professionals.
5. This is the first in a suite of papers on related issues in response to the Gisborne cervical screening inquiry and Helen Cull's "Review of Processes Concerning Adverse Medical Events". A separate paper will be prepared on complaints and discipline processes.

BACKGROUND

6. The eleven Acts currently administered by the Ministry of Health are:

Chiropractors Act 1982
Dental Act 1988 (Dentists, dental technicians, clinical dental technicians)
Dietitians Act 1950
Medical Auxiliaries Act 1966 (medical laboratory technicians, medical radiation technologists, podiatrists)
Medical Practitioners Act 1995 (MPA)
Nurses Act 1977 (which includes midwives)
Optometrists and Dispensing Opticians Act 1976
Occupational Therapy Act 1949
Pharmacy Act 1970
Physiotherapy Act 1949
Psychologists Act 1981

7. Most of these statutes are old, prescriptive and are unable to accommodate changes in technology and health professional roles in a changing health sector. With the exception of the Medical Practitioners Act 1995, none place a responsibility on registering authorities for the assessment of the continuing competence of practitioners.
8. A single, overarching Act, containing a framework for the governance and functions of registering authorities, would ensure consistency between the professions. It would also enable some currently unregulated professions, for example, osteopaths, to be regulated in the future without the need for separate Acts. New professions could be added by Order in Council.
9. The Ministry of Health has consulted with the current health statutory registration Boards and Councils, the Medical Disciplinary Tribunal, the Dentists Disciplinary Tribunal, and representatives from some unregulated occupations. A discussion document on the proposals was distributed widely in October 2000.

10. The HPCA has been allocated a priority 4 on the legislative timetable for 2001 – it is to be referred to Select Committee in 2001. Since then Helen Cull QC has reviewed complaints and disciplinary processes in the health sector and the report on the Gisborne cervical screening enquiry has been released publicly. There are implications in both for the HPCA. It is proposed that comprehensive legislation covering the HPCA, amendments to the Health and Disability Commissioner Act 1994, ACC legislation and other consequential amendments taking account of the recommendations of both reports, be introduced later this year.
11. This paper is the first in a suite of papers and covers the framework, registration process and competency provisions for the HPCA. It contains some of the recommendations from the two reports in relation to those issues. The complaints and disciplinary aspects of the HPCA will be the subject of a separate Cabinet paper once the implications of Helen Cull’s “Review of Processes Concerning Adverse Medical Events” have been considered.

COMMENT

12. Using the concepts in the Medical Practitioners Act 1995 (MPA) as a starting point, the HPCA would provide that
 - i registering authorities be responsible for ensuring practising practitioners maintain their competence
 - ii registering authorities be empowered to determine the requirements for registration
 - iii the registration and disciplinary functions be separated
 - iv both registration and discipline functions have lay participation
 - v separate, independent registering authorities for the different professions be continued
 - vi profession specific provisions be provided for.
13. The benefits of a single Act are:
 - a) *consistency* - a uniform approach could be taken to all occupations and changes would automatically apply to all professions
 - b) *flexibility* - enabling greater flexibility to meet changing skill sets, roles, diagnostic regimes and treatments
 - c) *transparency* - it could be easily seen which occupations were regulated and how
 - d) *simplification of regulating new professions* - new professions could be regulated by an amendment to the Schedules to the Act.

STRUCTURE OF THE HEALTH PROFESSIONALS' COMPETENCY ASSURANCE BILL

14. It is proposed that the principal purpose of the HPCA be to protect the health and safety of members of the public by prescribing or providing for mechanisms to ensure that health professionals are competent to practise.

Framework

15. The HPCA would be an enabling Act providing a framework for the mechanisms to be followed to assure the public that health professionals are appropriately qualified and competent to practise.

The proposed framework for the registration process is:

- The Act would specify the principles and processes which are to be adhered to by all registering authorities
- Provisions which need to adapt to technological and other changes in the health sector would be changed by Order-in Council under the authority of the Governor-General
- The Minister of Health would be responsible for appointments to and controls over registering authorities
- Registering authorities would determine the qualifications and competencies required to register health practitioners in a particular scope of practice
- Procedures for complaints and disciplinary procedures would be contained in the Act

A diagrammatic version of the framework can be found in Appendix 1.

Checks and balances on the power of registering authorities

16. Registering authorities would have the flexibility to determine the detail of their own rules and procedures, because of their knowledge of the professions. On the other hand, there is a risk that delegating too much authority to registering authorities may result in restrictive practices. To guard against this, I propose that the HPCA provide the following checks and balances:

- a) all members of registering authorities established under the Act be appointed by the Minister of Health, who will also have the power to dismiss members who are not adequately fulfilling their functions
- b) empower the Minister of Health to audit the registering authorities at any time
- c) separate registering authorities from each profession's association/union to avoid conflicts of interest
- d) separate disciplinary and registration functions
- e) lay representation on registering, investigatory and discipline bodies

- f) registering authorities to submit an annual report to the Minister of Health to be tabled in the House of Representatives
- g) require registering authorities to make public the rules and procedures for registration
- h) decisions of the registering authorities which affect individuals may be appealed to the District Court

Functions of registering authorities

17. It is proposed that the functions of registering authorities could include:

- a) Set minimum standards and competencies, which are necessary to protect the public, but do not unnecessarily restrict entry to the profession or impose undue costs on the profession or society
- b) authorise the registration of practitioners and maintain a register
- c) ensure practitioners are competent in their areas of practice
- d) consider applications for annual practising certificates
- e) review the competence of practitioners
- f) consider the case of practitioners who may not be fit to practise
- g) accredit and monitor training institutions or programmes
- h) exercise and perform such other functions, powers and duties as conferred on it by the HPCA
- i) receive and act on information from employers, ACC and the Health and Disability Commissioner on the competence of professionals
- j) provide information to employers, ACC, the Health and Disability Commissioner and other parties where there may be a risk of harm to the public from a professional's practise
- k) provide advice to the Minister of Health.

Registration

18. In order to obtain registration, an applicant must be able to satisfy the registering authority that he or she:

- a) has the necessary qualifications – paragraph 19
- b) is fit for registration – paragraph 20
- c) is competent within a scope of practise – paragraph 21.

Qualifications

19. Registering authorities should, within broad parameters, be able to establish the qualifications, including experience and training necessary for registration, for example, academic institutions, course syllabus, recognition of the jurisdiction of overseas registering authorities. To maintain a transparent process, registration requirements and any changes to procedure must be published in

the Gazette, and be publicly available. Although many do this in practice now, it is not required by legislation.

Fitness for registration

20. It is proposed that the Act contain explicit requirements as to fitness to practice. They could include:
 - a) An ability to communicate effectively in English
 - b) the absence of any convictions for an offence punishable by more than 3 months in prison that adversely affects the applicant's fitness to practise
 - c) the absence of any mental or physical condition which could adversely affect an applicant's fitness to practise
 - d) the applicant is not subject to any professional disciplinary proceeding; or an order of a disciplinary tribunal in New Zealand or in another country that might adversely reflect on the applicant's fitness to practise
 - e) satisfying the Council that the applicant has adequate skill and knowledge to practise.

Scopes of Practice

21. In a health sector that is changing and evolving due to new technologies and health professional roles, it is vital that the occupational regulation regime is dynamic and flexible enough to keep abreast of such changes and to accommodate an evolving health workforce.
22. Registering authorities should be empowered to define and set scopes of practice. A scope of practice refers to the services a practitioner is qualified and competent to offer, the parameters within which those services can be offered and a time period for review, for example, a generally registered doctor may be required to practice under supervision for a period of one year.
23. Scopes of practice will provide more flexibility than under current legislation by permitting a scope to be tailored for an individual, for example, an overseas-trained doctor could be granted registration to practice within a particular limited scope.
24. Annual practising certificates issued by registering authorities would include the scope of practice of a professional. Practitioners would be required to display their annual practising certificate at their place of work, if appropriate.
25. It is envisaged that scopes of practice would not be mutually exclusive between professions. Where members of two or more professions are qualified to provide the same service, the registering bodies should agree on consistent standards and competencies. Where the registering authorities cannot agree, the matter should be referred to the Minister of Health for resolution.

Health occupational regulation regimes - certification and licensing

26. Current health occupational regulation statutes employ two forms of regulation - certification and licensing. The most recent health occupational regulatory statute, the MPA, is a certification system, i.e. medical practitioners are certified as having the qualifications and competencies to practice medicine. No-one may practice under the title of a medical practitioner, or hold themselves out as being competent to practice as a medical practitioner, unless they are registered under the Act. However, a certification system does not prevent non-registered practitioners from practising provided they do not use a protected title. A generally registered medical practitioner, on the other hand, is able to use the title "Medical Practitioner" but is not prevented under the current legislation from practising, for example, cosmetic surgery without the appropriate qualifications.
27. Under a licensing regime, on the other hand, only a practitioner licensed to do so may undertake particular tasks, for example, dentistry under the current legislation.
28. The Ministry of Economic Development's guide, "Policy Framework for Occupational Regulation", favours certification regimes because of greater flexibility afforded by such regimes and the lesser likelihood that restrictive practices may occur.
29. However, the guide recognises that there may be a risk to the public in self-employed practices where there is not the added protection afforded by an employer who is accountable for safety in a health organisation. In these circumstances, licensing tasks, in addition to professional certification, provides improved safety to the public.
30. It would be desirable if the proposed Act provides a generic framework which could, as far as possible, apply to all the professions regulated under it. This could be achieved by a system, as is found in some overseas jurisdictions, that certifies that health professionals are qualified and competent to practice and licenses some tasks
31. I propose that the Act provide that registering authorities certify that health professionals are competent to practice within a scope of practice. In addition there would be a list of licensed tasks, which are of such an invasive nature as to pose a risk of irreversible harm to the public, that could be practised only by those practitioners who have licensed tasks specified in their scope of practice. The provisions of the Medicines Act 1981, the Misuse of Drugs Act 1975 and the Radiation Protection Act 1965 already provide for licensed tasks, for instance, prescribing.
32. Because of new technology that improves the way health services are delivered, it is proposed that the Governor-General, by Order in Council establish the list of licensed tasks, and amendments to it in like manner, after there has been consultation with the registering authorities. A list is being prepared and will be available before legislation is introduced.

33. Such a system would provide greater protection than is provided under the current legislation where there are invasive procedures with a significant risk of harm to the public, for example, all forms of surgery including cosmetic surgery would be licensed tasks.
34. It would, however, also provide flexibility by:
- providing a process for some groups, who may not pose a significant risk to the public, but where there is benefit to the public from having access to information about a practitioner's capability and competency, to register, for example, homecare workers
 - allowing practitioners, who do not pose a risk to the public, to practise without the need to be regulated, for example, massage therapists.
34. There would need to be adequate powers of enforcement to prosecute :
- certified practitioners acting outside their scope of practice
 - persons undertaking a licensed task which is not included in their scope of practice
 - uncertified persons holding themselves out to be certified in a scope of practice
 - uncertified people who cause patients irreversible harm in the course of providing health services.

Ongoing competence

35. It is proposed that the HPCA empower registering authorities to ensure the ongoing competence of health professionals by empowering them to review the competence of a practitioner at any time, and requiring them to do so if they have been notified that there is cause for concern. All health professionals would be required to participate in a competence review if directed to do so by the registering authority. Before commencing any competence review, the health professional would have been given notice setting out the reasons.
36. If it is considered that the practitioner should undertake a competence programme, the registering authority should be able to develop, or approve, a tailored competence programme to be undertaken by the practitioner, as well as being able to place conditions on practice. Every practitioner would have to be notified accordingly and given details of the programme within 30 days of the notification.

Notification of non-fitness to practise

37. To protect the public, colleagues and employers would have to notify the appropriate registering authority if they have reason to believe a person is not fit to practise because of some mental or physical condition or where they believe that a professional is practising below standard. The notifier would be protected from civil and criminal liability (provided that they have acted in good faith or without reasonable care).
38. There has been some debate as to whether colleagues should be required by law to report in these circumstances or whether it should be voluntary. On balance, I consider that because of the potential seriousness of some situations, a mandatory requirement will be more effective, notwithstanding the difficulties surrounding enforcing the provision.
39. Similarly, employers would have to notify the appropriate registering authority when a health professional has been dismissed or has resigned, for reasons relating to competence, fitness to practise, or poses a risk to the public. This avoids the practitioner from escaping accountability and enables the registering authority to tag the practitioner's record and/or require the professional to undergo a competence review.

Temporary Suspension

40. A registering authority should be empowered to temporarily suspend the registration of any person or place mandatory restrictions on practise
 - for a period of twenty days, where the practitioner is suffering from a mental or physical condition and the registering authority is satisfied that the disability renders the person unfit to practise safely. The registering authority may also require that the practitioner undergo a medical examination; or
 - where there are reasonable grounds to believe a health professional poses a risk to the public by practising below the standard required for members of the profession concerned. Because of the potential professional damage to a practitioner's reputation and career, a practitioner would have the opportunity to discuss with the registering authority whether the suspension is justified and, in the event of suspension, appeal any suspension. The length of the suspension would be for up to twenty days with provision of an extension after review.

Quality Assurance Activities

41. The MPA introduced the concept of quality assurance activities, which are defined as an activity that consists of an assessment or evaluation of any health services provided by a medical practitioner, where the assessment is carried out for the purpose of improving the practices or competence of the medical practitioner. The intention of such activities is to give medical practitioners a forum to discuss freely problems in their work, without fear of recrimination. Once the Minister of Health has 'declared' a quality assurance activity, the information that becomes known solely as a result of that activity is protected

and remains confidential. A person who provides information during a quality assurance activity is protected from civil liability.

42. It is proposed that the HPCA include similar provisions that cover all regulated health professionals. The extension of quality assurance provisions to all regulated health professionals reflects that care is often by multi-disciplinary teams. It is not intended, however, that they protect health professionals whose unsafe practices have exposed the public to harm.
43. In addition to retaining the provisions relating to quality assurance activities from the MPA, the following new provisions should be included in the HPCA:
 - a) as a condition of having an activity 'declared' as a quality assurance activity, each agency carrying out assessments for the purpose of the activity be required to provide the service provider with six-monthly reports, and the Minister of Health with an annual report. These reports should outline issues identified during the course of each year and describe what action has been taken to address the issues, based on the nature and extent of the activity being undertaken, the recommendations to be made as a result of the activity, the monitoring of the implementation of the recommendations, and improvements in competence or practice
 - b) minimum criteria be set as part of the Minister of Health's general ability to revoke a 'declared' quality assurance activity. These criteria should include failure to report, unsatisfactory reporting over any two year period taking into account the subject matter of the quality assurance activity, or failure to make satisfactory progress in the quality assurance activity taking into account its subject matter
 - c) a provision be included to enable the Director-General of Health to state, by notice in the *Gazette*, the minimum content and the form of a quality assurance application.

Appointment of registering authorities

44. The HPCA should incorporate the general principles in the current legislation which are that:
 - a) the Minister of Health appoint board members, in consultation with interested organisations
 - b) the composition of the Boards include lay participation
 - c) the boards and councils are bodies corporate, with the rights, powers and privileges of a natural person of full age and capacity
 - d) the Minister of Health may, in consultation with the Board, remove appointed members whose performance is inadequate.
45. The current exceptions to the principle of ministerially appointed members are the Medical, Dental and Pharmaceutical Councils that have a minority of elected members. These Councils argue that members should be elected from

the profession so there is some direct accountability. One submission quoted, “no taxation without representation.” It is likely that the same arguments will be made again.

46. There may be accountability conflicts if board members represent a particular professional or interest group, such as consumers.
46. The Health and Disability Commissioner Act 1994 deals specifically with consumer interests, whereas the HPCA is about ensuring that health professionals are competent to practise in order to protect the public. The provision for lay or non-professional members allows a mix of skills, for example, legal or economic, not just a consumer perspective.
47. The question of whether Māori representation on the registering authorities should be required by legislation also needs to be considered.
48. An understanding of Māori health issues and perspectives and the role of the Treaty of Waitangi in the health sector is essential in the delivery of effective services in New Zealand, and must be built into the training of health professions. Similarly, health professional standards must be as appropriate for Māori consumers as they are for other consumer groups. Since the establishment of professional standards is a key function of the registration authorities, there is a role for Māori membership on boards – and in practice most boards currently have Māori members.
49. Māori membership on registering authorities needs to be balanced, however, against other factors:
 - The boards need to be small enough to be manageable (a maximum of 7 people) and yet have sufficient numbers of people with the technical knowledge of the regulated profession to carry out their statutory functions – experience indicates that the bulk of registration work falls to the professional representatives
 - Costs also need to be kept down since the authorities are funded by the professionals themselves
 - Māori perspectives may be more critical to some authorities than others – especially nurses, doctors and dentists – and less so for others.
50. Māori membership on registering authorities is to be encouraged, but to allow the flexibility to balance all these factors, it is recommended that rather than this being a statutory requirement, the issue be included in protocols and practices for appointing members to the authorities.
51. On balance, I recommend that all members should be appointed and that the legislation provide for a mix of professional and lay members. This will provide flexibility to ensure that there is an appropriate mix of skills, consumer interests, gender and ethnic perspectives on each of the different registering authorities. Protocols for appointment should be put in place to ensure that this occurs and

that the concerns of Māori and consumers are reflected in the decision making process.

Miscellaneous provisions

52. It is proposed that:

- the chairperson of each registering authority have the power to delegate its functions, duties and powers to the registrar
- Members and officers and employees of registering authorities be protected from criminal or civil liability in respect of acts done in good faith and with due care in the course of performing their functions.

Inclusion of additional health professions in HPCA

53. The government is committed to the regulation of health professionals. I propose that all groups who are currently regulated by statute continue to be regulated under the HPCA and that these be set out in a Schedule to the Act. The HPCA would contain an empowering provision so that, from time to time, the Governor General, by Order in Council, can add new professions who provide health services to the Schedule or remove professionals from the Schedule if regulation is no longer necessary.

54. The HPCA would contain provision for the Minister of Health to initiate a registration process if there is reason to believe that a profession poses a risk of harm to the public.

55. Unregulated groups wishing to gain registration would have to demonstrate to the Minister of Health that the public is at risk of harm by the practice of the profession or that the public interest would be served by their inclusion in the Act. Regulation would be in accordance with the government's overall regulatory framework. Groups would need to establish that effective procedures are in place regarding:

- Recognised qualifications
- Standards
- Scopes of practice
- Competence
- Any other relevant information

56. Once a decision has been made by the Minister of Health to regulate a profession, the process of appointing a registering authority would begin in consultation with the sector.

Audit of registering authorities

57. In order to provide a check and balance on the power of registering authorities it is proposed that the Minister of Health have the power to audit registering

authorities at any time. The Minister could direct authorities in respect of their policies, but not be able to intervene on individual cases. The findings of the audit would be made publicly available.

Profession specific provisions

58. The only issue raised to date in this context, which cannot be dealt with under the general framework, is the question of the ownership of pharmacies. A separate paper is being prepared on this question and proposed amendments to the Medicines Act 1981 to ensure safe systems of distribution of medicines.

CONSULTATION

59. A discussion document was publicly released on 3 October 2000. A summary of the 180 submissions received is contained in Appendix 2.
60. The following government agencies have been consulted in the preparation of this paper: Ministry of Economic Development; Treasury; Ministry of Foreign Affairs and Trade; Ministry of Women's Affairs; Ministry of Education; Ministry of Justice; Ministry of Social Policy, Ministry of Pacific Island Affairs; Ministry of Labour; Ministry of Consumer Affairs, Te Puni Kokiri; State Services Commission and the Department of Prime Minister and Cabinet and their views are reflected in this paper.
61. The Ministry of Women's Affairs considers that it should be stipulated in the legislation that there be consumer and Māori representation on the registering authorities to protect against "professional capture".
62. The Ministry of Consumer Affairs is concerned about the proposal to continue with a minority of laypersons on the registration boards, investigating committees, and Tribunals. The Health and Disability Commissioner Act 1994 (which embodies the Code of Health and Disability Consumers' Rights) uses the term consumer, and the Ministry suggests that the HPCA Act be made consistent with this Act. Further the Ministry of Consumer Affairs believes that consumers will only gain the level of protection envisaged in the Act if a robust relationship between health professionals (GPs, academics, specialists) and consumers is established within the Boards. This is an environment where decisions need to be the outcome of a rigorous contest between two equal parties.

FINANCIAL IMPLICATIONS

63. The potential costs of the proposals in this paper are identified in the attached draft Regulatory Impact and Compliance Cost Statement Costs may be passed on to health professionals by way of increased fees, although they may be reimbursed by employers (including district health boards).

64. The Ministry of Health is not seeking additional funds to meet these costs at this stage.

LEGISLATIVE IMPLICATIONS

65. The HPCA has a priority 4 on the 2001 legislative timetable.

HUMAN RIGHTS ACT 1993

66. The recommendations in this report are consistent with the Human Rights Act 1993.

REGULATORY IMPACT AND COMPLIANCE COST STATEMENT

67. A draft Regulatory Impact and Compliance Cost Statement is attached. The statement will be finalised when the suite of papers on related issues in response to the Gisborne cervical screening inquiry and Helen Cull's "Review of Processes Concerning Adverse Medical Events" have been considered. The Regulatory and Compliance Unit of the Ministry of Economic Development has been consulted and supports this approach.

PUBLICITY

68. A press release will be prepared when the legislation is ready for introduction to the House.

AT THE MEETING ON 14 MAY 2001, FOLLOWING REFERENCE FROM THE CABINET HEALTH AND EDUCATION COMMITTEE (EHC), CABINET:

CAB (01) M 15/1

HEALTH PROFESSIONALS' COMPETENCY ASSURANCE BILL

- 1 **noted** that the paper under EHC (01) 16 is the first of a suite of papers on related issues in response to the Gisborne cervical screening inquiry and Helen Cull's "Review of Processes Concerning Adverse Medical Events";
- 2 **agreed** that the proposed Health Professionals' Competency Act (HCPA) replace the current 11 health occupational regulation Acts;

Purpose

- 3 **agreed** that the purpose of the Act be to protect the health and safety of members of the public by prescribing or providing for mechanisms to ensure that health professionals are competent to practise;

Establishment

- 4 **agreed** that, for each regulated occupational group, a registering authority be established to:
 - 4.1 set minimum standards and competencies for registration which are necessary to protect the public, but do not unnecessarily restrict entry to the profession or impose undue costs on the profession or society;
 - 4.2 authorise the registration of practitioners and maintain a register;
 - 4.3 ensure that members of its profession are competent in their areas of practice;
 - 4.4 consider applications for annual practising certificates;
 - 4.5 review the competence of practitioners to practise;
 - 4.6 consider the case of practitioners who may not be fit to practise;
 - 4.7 accredit and monitor training institutions or programmes;
 - 4.8 exercise and perform such other functions, powers and duties as conferred on it by the HPCA;
 - 4.9 receive and act on information from employers, ACC and the Health and Disciplinary Commissioner on the competence of practitioners;
 - 4.10 provide information to employers, ACC, the Health and Disability Commissioner and other parties where there may be a risk of harm to the public from the practice of the professional;

- 4.11 provide advice to the Minister of Health;
- 5 **agreed** that each registering authority be established as a body corporate, which gives it the rights, powers and privileges, and can incur the liabilities and obligations, of a natural person;
- 6 **agreed** that the HPCA:
- 6.1 provide that all members of registering authorities be appointed by the Minister of Health and that the Minister has the power to dismiss members of registering authorities;
 - 6.2 contain a provision empowering the Minister of Health to audit the registering authorities at any time and direct them on matters of policy;
 - 6.3 separate registering authorities from each profession's association/union to avoid conflicts of interest;
 - 6.4 require lay representation on registering, investigatory and disciplinary bodies;
 - 6.5 require that registering authorities submit an annual report to the Minister of Health which will be tabled in the House of Representatives;
 - 6.6 require registering authorities to make public the rules and procedures for registration;
 - 6.7 provide that appeals against decisions of registering authorities which affect individuals lie with the District Court;

Registration

- 7 **agreed** that registering authorities be empowered to establish the requirements for registration;
- 8 **agreed** that the requirements for registration established by the registering authorities be published by notice in the *Gazette*;
- 9 **agreed** that fitness for registration include:
- 9.1 the ability to communicate effectively in English;
 - 9.2 the absence of convictions for an offence punishable by more than three months in prison, which might adversely affect the applicant's fitness to practise;
 - 9.3 the absence of any mental or physical condition that would adversely affect an applicant's ability to practise;
 - 9.4 that the applicant is not subject to any professional disciplinary proceeding, or under an investigation that would adversely reflect on the applicant's fitness to practise;

- 9.5 satisfying the registering authority that the applicant has the adequate skill and knowledge to practise;
- 10 **agreed** that a health professional is entitled to registration if he/she has met the qualifications determined by the registering authority and fitness for registration requirements;
- 11 **agreed** that the HPCA empower the registering authority to determine the information required on the registration form, and set registration and other fees;
- 12 **agreed** that the HPCA set out the information required on a register and require the register to be open for public inspection;

Scopes of Practice

- 13 **agreed** that registering authorities be empowered to establish scopes of practice which refer to the services that a practitioner is competent to offer, the parameters within which those services can be offered and a time period for review;
- 14 **agreed** that general scopes of practice should be published in the *Gazette*;
- 15 **agreed** that registering authorities be empowered to establish tailored scopes of practice for individuals;
- 16 **agreed** that disputes between different professional groups be referred to the Minister of Health for resolution;

Certification of Health Professionals

- 17 **agreed** that:
- 17.1 the HPCA be based on a certification regime;
- 17.2 some titles may be protected under the Act;
- 17.3 no person shall practise under a registered title unless they are registered under the HPCA, and hold a current practising certificate;
- 17.4 no person shall hold themselves, or any other person out, as being entitled, qualified or able to practise under a registered title, unless they are registered;
- 18 **agreed** that no one, other than a certified health professional acting within the scope of practice of his/her profession, shall deliver health services in circumstances in which it is reasonably foreseeable that irreversible harm may result from the delivery or omission of such services;

Licensing

- 19 **agreed** that the Governor-General may, by Order in Council, establish a list of licensed tasks that can be performed only by practitioners who are certified to do so according to their scope of practice;

Enforcement

- 20 **agreed** that the Bill contain adequate enforcement provisions to ensure registered practitioners do not practise outside their competencies and unregistered persons do not practise illegally;

Annual Practising Certificate

- 21 **agreed** that registering authorities be empowered to issue annual practising certificates that include a health professional's scope of practice;
- 22 **agreed** that registering authorities have the power to decline to issue a certificate if satisfied that any information included in the application is false or misleading;
- 23 **agreed** that the registering authority be empowered to decline to issue an annual practising certificate or set conditions on a health professional's practice if the authority believes the professional has failed to maintain a reasonable standard of professional competence;

Ongoing Competence

- 24 **agreed** that registering authorities be empowered to review the competence of a health professional at any time, and be required to review it after receiving a notification that there is reasonable cause for concern;
- 25 **agreed** that health professionals be required to undertake a competence review if requested to do so by the registering authority;

Notification of Non-fitness to Practise

- 26 **agreed** that the HPCA contain provisions that require;
- 26.1 colleagues and employers to report health professionals who may not be fit to practise due to a mental or physical condition, or where they believe that a health professional is practising below an acceptable standard, to the appropriate registering authority;
- 26.2 employers to notify the appropriate registering authority when a health professional has been dismissed or has resigned for reasons relating to competence, fitness to practise or posing a risk to the public;
- 27 **agreed** that notifiers be protected from civil and criminal liability provided that they have acted in good faith and with reasonable care;

Temporary Suspension

- 28 **agreed** that registering authorities be empowered to temporarily suspend, or place conditions on, the registration of any person suffering from a mental or physical condition for 20 working days if, in the opinion of the registering authority, the disability renders the person unfit to practise safely;
- 29 **agreed** that the registering authority may require a practitioner believed to be suffering from a mental or physical condition to undertake a medical examination;
- 30 **agreed** that registering authorities be empowered to suspend for a period of 20 days with provision to extend after review or place conditions on a health professional's practice, where it is considered the health and safety of the public are at risk;

Declared Quality Assurance Provisions

- 31 **agreed** that the HPCA contain declared quality assurance provisions (based on Part VI of the Medical Practitioners' Act 1995) which protect the confidentiality of information and give immunity from civil liability to persons who engage in such activities in good faith;

Inclusion of Health Professions in the HPCA

- 32 **agreed** that the Governor-General, by Order in Council, may amend the Schedule of professions regulated under the HPCA by adding new professions to, or deleting existing professions from, the Schedule;
- 33 **agreed** that all the groups that are currently regulated continue to be regulated under the new legislation;
- 34 **agreed** that the Minister of Health appoint board members, in consultation with interested parties, and that they include lay members;
- 35 **agreed** that the HPCA contain a process for regulating new professional groups;

Miscellaneous Provisions

- 36 **agreed** that the HPCA contain provisions for protection of members and officers and employees of registering authorities from any criminal or civil liability incurred in performing their functions;
- 37 **agreed** that the chairperson of each registering authority have the power to delegate its functions, duties and powers to the registrar;

Complaints and Disciplinary Processes

- 38 **noted** that a separate paper is being prepared for the Cabinet Education and Health Committee on the complaints and disciplinary processes for health professionals;

Profession Specific Provisions

- 39 **noted** that a separate paper is being prepared for the Cabinet Education and Health Committee on the provisions relating to the ownership of pharmacies;

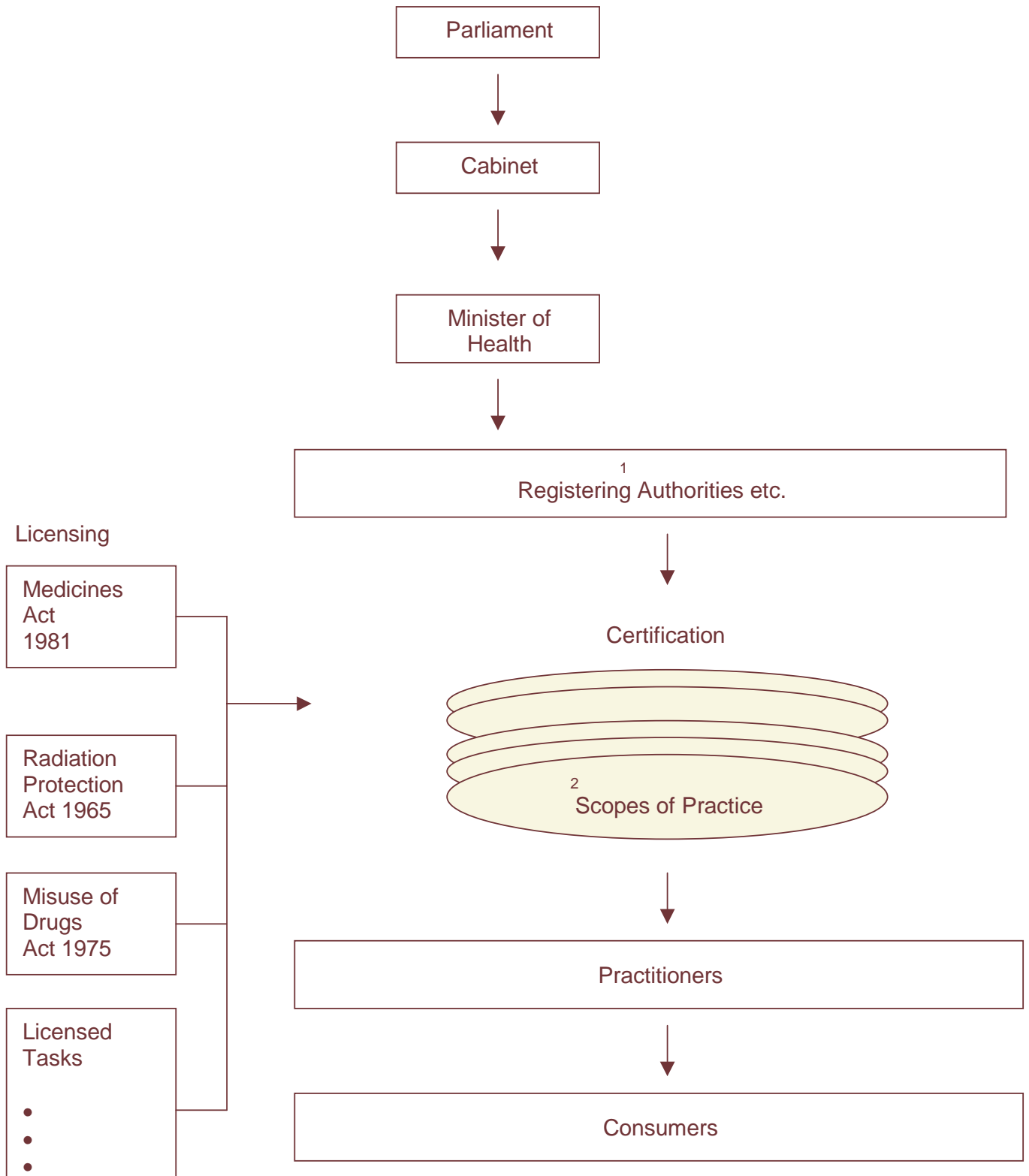
Financial Implications

- 40 **noted** that there may be increased costs for occupational groups as a result of this proposal and that some of these costs may be passed on to District Health Boards (DHBs);
- 41 **noted** that costs incurred by the Ministry of Health or DHBs for proposals in this paper will be met by reprioritisation within Vote Health baselines;
- 42 **noted** that further costs may be identified in the suite of papers on complaints and discipline processes and in response to the Gisborne cervical screening inquiry and Helen Cull's "Review of Processes concerning Adverse Medical Events" and that the final Regulatory Impact and Compliance Cost Statement will be presented with those papers;

Drafting Instructions

- 43 **invited** the Minister of Health to issue drafting instructions to Parliamentary Counsel to give effect to the above decisions.

Appendix 1:



1. The number of registering authorities will depend on the number of professions regulated under the Act.
2. Scopes of Practice can overlap within professions and across professions.

Appendix 2:

Summary of Submissions on the Health Professionals' Competency Assurance Bill Discussion Paper

- Strong support (96%) for single Act, provided that concerns and points of view of submissions are addressed.
- Unanimous support for purpose statement to be included in Act.
- Fitness to practice and qualifications must be requirements for registration, while practical experience could be discretionary for each registering authority.
- Highly supportive (96%) of registering authorities being empowered to set registration requirements, as long as the processes and criteria are transparent.
- Support (94%) for scopes of practice but would like consistency between professions and want clarification on procedures when different professions have overlapping scopes of practice – i.e. who sets the competency requirements?
- Much debate around the certification and licensing issue with just over half of submissions supporting some form of certification.
- Strong support (98%) for registering authorities to have the ability to impose conditions on annual practising certificate, or not to issue one at all.
- Unanimous support for registering authorities to be empowered to review competence of practitioners, however some concern about costs of on-going competence regime.
- Support for provisions to require colleagues to report practitioners reasonably believed to be suffering from a mental or physical condition, and practitioners believed to be practising below an acceptable standard. However, want transparent process with further definition of terms, appeal process, and mechanisms to deal with vexatious complaints. Many submissions want compensation for practitioner where the complaint cannot be upheld.
- Support (85%) for registering authorities to be empowered to suspend practitioners where it is believed they are suffering from a mental or physical condition. However, many submissions commented that 20 days suspension was too long.
- Support (97%) for registering authorities being empowered to temporarily suspend practitioners or place conditions on their practice where it is believed that the public is at risk.
- Strong support (99%) for quality assurance provisions to be extended to all health professionals.

- Much debate and comment about discipline processes. Want processes with Accident Compensation Corporation (ACC), Health and Disability Commissioner (HDC), registering authorities and disciplinary tribunal(s) to be streamlined to prevent delays and multiple investigation of the same complaint.
- Debate whether Complaints Assessment Committees (CACs) should be established from members of registering authority or external panel. One third of submissions did not support CACs having power to resolve minor complaints by imposing fines, but many submissions supported conciliation.
- Strong support (94%) for CACs to report to registering authority if they believe members of the public have been put at risk, or will be in the future.
- 81 percent of submissions supported the proposal for discipline functions to be separated from registration functions. If registration and functions are separated, over a half of submissions would prefer a multidisciplinary tribunal.
- Agreed that disciplinary tribunals should be able to impose a range of penalties.
- 82 percent of submissions supported appeals against decisions of tribunals be heard by a District Court. Some submissions suggested appeals should be heard in the High Court, while others suggested the establishment of another appeals body.
- Three-quarters of submissions supported the current regime of registering authority appointments, which allows the Minister of Health to appoint board members in consultation with interested organisations.¹ Lay participation is supported, with many submissions wanting the number of lay participants increased. It was debated whether lay members should be representatives from a health consumer organisation.
- Strong support for registering authorities to be audited.
- Over half of submissions did not support different levels of registration, with many commenting that it would cause confusion to the public.

¹ The Medical, Dental and Pharmaceutical Councils currently have the provision to elect some members, and would like to retain this provision.

REGULATORY IMPACT AND COMPLIANCE COST STATEMENT: HEALTH PROFESSIONALS COMPETENCY ASSURANCE BILL

STATEMENT OF THE PUBLIC POLICY OBJECTIVE

1. The public policy objective is to protect the health and safety of the public.

STATEMENT OF THE PROBLEM AND NEED FOR ACTION

2. With the exception of the Medical Practitioners Act 1995 (MPA), the current eleven regulatory statutes which establish registering authorities are out-of-date. They are, in many cases, inflexible, prescriptive and do not meet the needs of consumers or the relevant professions.

STATEMENT OF OPTIONS FOR ACHIEVING THE DESIRED OUTCOME

Non-regulatory measures

3. The alternative to statutory regulation is reliance on industry self regulation. It is considered that this would not provide adequate protection for the public.

Regulatory measures

4. There are two statutory regulatory options available –amending the existing Acts individually or introducing a single Act to provide a framework for all health professions where there is a risk of harm to the public.

STATEMENT OF THE NET BENEFIT OF THE PROPOSAL

The net benefits of the proposal are that

- the existing statutes will be replaced by one Act providing a consistent framework for the regulation of health professionals which can accommodate future changes in technology and the delivery of health services. This will mean administrative savings because of fewer amendments and, if an amendment is necessary, only one piece of legislation needs to be changed
- there will be enhanced protection for the public from the extension of the ongoing competency provisions in the MPA to the other regulated professions
- more flexibility will assist in ensuring that there are appropriately qualified and competent practitioners available to practise in areas of need
- more streamlined complaints and disciplinary processes will be less stressful for complainants and result in earlier resolution of complaints

BUSINESS COMPLIANCE COST STATEMENT

Direct costs

5. Statutory regulation of health professionals is already in place. The direct costs of administering the functions of the current registering authorities, including disciplinary procedures, are met by the annual registration fees paid by members. These vary from \$32 for nurses (47,000 registered practitioners) to \$485 for medical practitioners (13,500 registered practitioners). The Dental Council estimates that it costs about \$400 per registered practitioner (1,385 registered practitioners) to run the Council's registration and disciplinary processes.
6. The medical practitioners fee already meets the cost of competency reviews under the MPA. Other registering authorities, however, may incur additional costs by the new provisions relating to ongoing competence. Obviously, members of the smaller professions will have greater difficulty in absorbing the additional costs than the larger groups, such as the nurses. It costs the Medical Council on average \$3,700 to review a practitioner's competence. This is likely to be at the higher end of the average cost because of the complexity of a medical practitioner's scope of practice.
7. The Councils currently carry out similar functions as to those proposed in the new legislation and increases in fees because of the new legislation should be minimal.
8. Registering authorities will pass any increased costs on to the profession by way of increased fees. Some of these costs may be reimbursed by the Crown (there will be approximately 73,000 health practitioners registered under the Bill of whom approximately 32,000 are employed by District Health Boards) while other professions may pass costs on to consumers by increased prices and consultancy fees. As an example of the impact, an average \$40 increase in fees for 73,000 registered practitioners would amount to \$2,920,000.
9. The current costs of disciplinary processes are met by the annual registration fees. [A final assessment of the compliance costs of new complaints and disciplinary processes will be included in a further paper].

Indirect Costs

10. Regulation also imposes indirect costs on the sector. For example, the provisions in the HPCA for competency reviews and programmes, may result in professionals undertaking more training programmes; if the regulation unnecessarily restricts who may practise, there could be labour shortages leading to upward pressure on wages and prices.

CONSULTATION

11. The Regulatory and Compliance Cost Unit of the Ministry of Economic Development has been consulted.