2012 Review of the Heath Practitioners Competence Assurance Act 2003

New Zealand Medical Association Submission

NZMA
NZMA House
26 The Terrace
PO Box 156
Wellington

Phone: 04 472 4741
Facsimile: 04 471 0838

lesley@nzma.org.nz

2012 Review of the Health Practitioners Competence Assurance Act 2003

"In a well-arranged community a citizen should feel that he can at any time command the services of a man who has received fair training in the science and art of medicine, into whose hands he may commit with safety the lives of those near and dear to him."

William Osler 1885[1]

1. Introduction

About the NZMA

The New Zealand Medical Association (NZMA) is New Zealand's largest medical organisation and has a pan professional membership. We have more than 5,000 members who come from all areas of medicine including medical students, resident medical officers, general practitioners, and other specialists.

The NZMA aims to provide leadership of the medical profession, and promote:

- professional unity and values, and
- the health of all New Zealanders.

The key roles of the NZMA are to:

- provide advocacy on behalf of doctors and their patients
- provide support and services to members and their practices
- publish and maintain the Code of Ethics for the profession
- publish the New Zealand Medical Journal.

Patient safety and quality of care is dependent on a system that ensures the development and application of standards for the health profession, its education, training, registration and practice. The medical profession understands this and demands excellence of itself and those that join it.

Professional Regulation

The NZMA continues to strongly support the concept and principle of professional self-regulation where reliance is placed on the internal morality of professional groups to govern themselves within an overall statutory framework. Although the concept of professional self-regulation continues to evolve, particularly in respect of improved transparency, greater involvement of lay people and broader accountabilities, it remains the cornerstone of professionalism and therefore the key to safe and effective health services for New Zealand. In the words of sociologist William Sullivan, neither economic incentives, nor technology, nor administrative control has proved an effective surrogate to a commitment to integrity evoked in the ideal of professionalism[2].

[1] The Growth Of A Profession. Can Med Surg J 1885-86;14:129-55

[2] Sullivan W. Work and integrity: the crisis and promise of professionalism in North America. New York: Harper Collins; 1995. p. 16.

Professionalism itself is defined as the mastery of a complex body of knowledge, hand in hand with an ethical commitment to integrity, morality and altruism. These skills and attitudes are used in the service of others as the basis of a social contract between the medical profession and the community. Society in return grants the profession the privilege and the responsibility of self-regulation and autonomy in practice.

The World Medical Association has also stated in its Declaration on Professionally-led Regulation[3] that as a corollary to the right of professional autonomy and clinical independence, the medical profession has a continuing responsibility to be self-regulating. The NZMA is therefore strongly of the view that required standards of patient safety and quality of care can only be achieved through the autonomous process of registration and competence assurance by independent bodies that involve the highest level of professional expertise and input, free from political and bureaucratic interference.

Any erosion of the independence of regulatory bodies or moves to further diminish the professional leadership of these bodies will potentially remove a key enabler and motivator for professionalism, in turn weakening the social contract that currently exists.

The NZMA acknowledges that the privilege of self-regulation rests in public trust and confidence and to retain this privilege the profession must deal appropriately and transparently with its members who do not perform to an acceptable standard and that the profession collectively must continue to fulfil its duty of public service. The role of the statutory framework for professional regulation in the health sector must therefore be to establish conditions where that trust can be maintained and professionally-led regulation operates rigorously, openly and consistently.

Context of Review

The NZMA notes that the 2009 report[4] on the operation of the Health Practitioners Competence Assurance (HPCA) Act 2003 recommended that a review of the underlying policy settings of the HPCA Act is undertaken in 2012.

A review of policy settings relating to professional regulation is not a small matter and is one that potentially has major impact on the livelihood and practice of every individual health practitioner as well as the performance of each of the professions and the entire health workforce in New Zealand.

The NZMA is therefore concerned about the relatively short timeframe offered to professional groupings and other stakeholders to consider and debate the policies and principles that determine the regulatory framework that we work within and are paramount for ensuring the safety of New Zealanders.

We also note that the document revisits a number of the operational issues canvassed during the 2008/09 review. Following extensive consultation 37 recommendations regarding legislative and operational matters, including better information for the public, collaboration and cost containment, and key performance indicators were made at that

[3] **WMA Declaration of Madrid on Professionally-led Regulation** Adopted by the 60th WMA General Assembly, New Delhi, India, October 2009. http://www.wma.net/en/30publications/10policies/r4/index.html

[4] Review of the Health Practitioners Competence Assurance Act 2003 – June 2009 Report to the Minister of Health by the Director-General of Health

time. It is disappointing that little progress on these proposed improvements have been made and as a result these matters are still on the table.

The NZMA also notes the work of the Cabinet Economic Growth and Infrastructure Committee in 2009[5] which was charged with the task of indentifying inefficient and superfluous regulation that could be removed. In considering the HPCA Act the Committee considered matters relating to the process for registration of overseas trained practitioners, authorisation of scopes of practice, ministerial audit and time taken to process applications. Cost was not raised as a matter of concern by the Committee who ultimately recommended that no immediate regulatory reform was necessary and deferred any wider policy review for the planned 2012 review "when more evidence of concerns may be available".

Unfortunately the 2012 review has commenced with a complete absence of evidence of concern, despite the lengthy time since possible areas for examination had been identified. We are very concerned that unsubstantiated statements of failings and flaws in the statutory framework and its operations are being made without any evidence being provided or any consideration of the use of existing provisions of ministerial audit to review and address these matters as they arise.

In addition to the absence of evidence relating to the concerns raised in the discussion document, there is also a complete absence of evidence that a move away from the current regulatory model would achieve improvements and no detail of what could be changed legislatively and why, and what outcomes would be expected if those changes were made.

In summary therefore, the case for change has not been made and, as the HPCA Act is currently achieving its purpose, the rationale for a major shift in policy does not exist.

2. Discussion Document – policy settings

Workforce delivery

Of the matters raised in the consultation document a key policy issue centres on the influence of regulatory settings on workforce responsiveness.

To consider this matter a determination must first be made as to the primary role of regulation of health professions and therefore the purpose of the Act.

The stated purpose of the HPCA Act is to "protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practice in their professions".

These mechanisms include the determination of who is permitted to be a registered member of a health profession; ensuring that those who are registered are practicing competently and safely, and allowing the removal or limitation of practice of those who are found to be unfit to continue to practice autonomously.

[5] Regulatory Review Programme: Immediate Removal of Inefficient and Surperfluous Regulation. http://www.treasury.govt.nz/economy/regulation/programme/pdfs/egi-09-7.pdf

The NZMA endorses this central purpose which provides clarity of function and does not, as stated in the introduction to the discussion document, require a balancing of competing priorities. Indeed, the implied proposition in the discussion document that the Act should also be a tool to respond to workforce priorities or influence workforce directions would inevitably create conflicting priorities for Responsible Authorities (RAs) that do not exist at this time. It is not the role of the HPCA Act to deliver the workforce but rather to ensure, and provide public confidence, that the workforce that is delivered is safe and competent.

Incorporating professional regulation as a component of workforce strategy is a major move away from the clear purpose of the HPCA Act. Such a move would entail adjustment of standards and decision making as priorities move with changing political directions and labour market pressures. Loosening or tightening professional regulation in response to these external influences in this way would damage the integrity of the regulatory function and turn what is essentially regulation of the individual for public protection into a mechanism to manage the workforce.

This would have the ultimate effect of creating a system that is not 'fit for purpose' as the core purpose of public protection is eroded due to conflicting objectives. It would also diminish the standing of New Zealand health practitioners internationally and the relative standing of the New Zealand health system. We have come a long way since the *Lancet*[6] referred to New Zealand as "a happy home for every kind of unfeathered quack" and we must strive to ensure that we maintain our standards and good reputation.

Standards for entry

Concerns relating to the possible anticompetitive behaviour of the professions are also raised in the discussion document with the statement made that standards must be set at the level required to ensure public safety, and not at a higher level that provides more economic benefits to the health profession than is warranted.

Given that New Zealand has a high dependency on overseas doctors it is vital that we require these doctors to meet the same standards as those trained here and ensure they are to function safely and effectively in the New Zealand environment. This is critical in maintaining public confidence in the profession and considerations must go beyond simple examination of existing clinical qualifications.

The fact that 43% of our current medical workforce did not train in New Zealand, and we have doctors practising in New Zealand from many different countries, would suggest that the current standards are not a significant barrier to overseas trained doctors.

Section 13 of the HPCA Act states that the qualifications prescribed by RAs must be necessary to protect members of the public and must not unnecessarily restrict the registration of persons as health practitioners or impose undue costs on health practitioners or the public. Further, Section 124 of the Act allows the Minister audit RAs to ascertain whether the RA is complying with the provisions of the Act, including, without limitation the principles set out in Section 13.

[6] Lancet 1897 (1):490

The NZMA is therefore of the view that there is adequate provision in the Act to ensure that entry requirements are appropriately set for safety requirements. If there are concerns that this is not the case or that anticompetitive activity is taking place the RA in question can be independently audited. The NZMA is unaware of any such audits being initiated in the almost 10 years since the Act came into force and if there is evidence that these issues exist we would suggest that the first course of action be to use these existing provisions rather than consider regulatory changes to address a hypothetical concern.

Workforce flexibility

It is also suggested that the current legislation and the way it has been operationalised has resulted in workforce inflexibility that is detrimental to establishing multidisciplinary teams and is hindering the drive towards improved integration in the sector. This relates to a view that some scopes of practice are too narrow to allow role extension and that there are difficulties encountered when extended scopes overlap with the existing scopes of other professional groups.

The HPCA Act does not prescribe scopes of practice, it simply requires that scopes are defined and that the RAs ensure that individual practitioners are competent to practice within their scope. The Act provides mechanisms (sections 127 and 128) to resolve disputes between RAs regarding overlapping scopes of practice and allows the Minister to intervene and ultimately give direction via an appointed expert panel.

As with standards of entry, above, the NZMA is unaware of any cases where dispute resolution provisions have been formally employed and there have been no instances of Ministerial intervention in the decade the legislation has been in operation. Scopes of practice have evolved significantly for many professions over this time and will continue to do so as new models of care and workforce innovations are developed.

The discussion document does not elaborate with examples or scenarios of workforce problems resulting from scopes of practice, or the legislative requirements of the HPCA Act generally. Again, the NZMA is therefore of the view that there is already adequate provision in the Act to address such issues if they arise.

We would also comment that effective team work cannot be legislated for. Effective teams work in a culture of trust and respect. Doctors possess the ability to work as members of healthcare teams, recognising and respecting the skills and attributes of other practitioners[7]. Clarity of roles and scopes of practice therefore serve to enhance teamwork rather than detract from it. Conversely uncertainty regarding role and scope could cause tensions within the team and potentially create risk for the patient and the professionals involved.

The NZMA understands that the Council of Medical Colleges (CMC) has suggested that existing requirements under the HDC Code of Patient Rights and codes of ethical conduct regarding co-operation and communication among providers could be reflected in the HPCA Act, perhaps via an explicit addition to the Section 118(j) requirement of RAs to liaise with each other on matters of common interest. The NZMA would support further exploration of this option.

[7] Consensus Statement on the Role of the Doctor in New Zealand – NZMJ 4 November 2011, Vol 124 No 1345

Value of statutory regulation

The executive summary of the discussion document states, under the heading of 'safety focus', that it is necessary to consider whether there is an appropriate balance between the safety concerns of employers and the requirements of government regulation. As an example the question is asked "if employers already have all of the systems in place for groups of health professionals to keep the public safe from harm, what additional value does statutory regulation have in this situation?"

This proposition confuses the need to regulate individual practitioners, regardless of employment status and practice setting, with the need for employers to operate whole-of-business quality management systems. It also appears to suggest that health practitioners who are salaried could be exempt from professional regulation which would give rise to a number of issues.

The main flaws in the argument that employer based safety provisions are sufficient and could replace professional regulation are:

- Even large employers such as DHBs would struggle to assess entry requirements and ongoing competency of any single professional group yet alone the multiple professional groups that are employed across the organisation.
- A dual system would need to continue to regulate those professionals who are self- employed, in independent practice, or employed by smaller organisations such as private clinics and hospitals, community pharmacies, rest homes etc.
- Conflicts would be a significant risk as employers juggle operational needs with quality and safety.
- The relative standing of New Zealand's health professions would be diminished internationally.
- The principle of professionally-led regulation would be lost.
- A consistent accountability regime for all health professionals would cease to exist.
- Variation across employers would arise as we have already seen with credentialing processes.

The NZMA is also of the view that DHBs have a poor track record of dealing with professional accountability. This is evidenced in a recent Section 95 Inquiry[8] into mental health services delivered by Hutt Valley DHB. The inquiry found serious failures at managerial levels that had significant bearing on the patient incidents involved. A clinician was held accountable for apparent failure in care and was referred by the Director of Mental Health[9] to the Medical Council for investigation and possibly disciplinary action. However those managers who were found to have made poor

[8] Findings of an Inquiry Under Section 95 of the Mental Health (Compulsory Assessment and Treatment) Act 1992: An inquiry into Hutt Valley District Health Board Mental Health Service including the clinical management of certain patients and the operation of the Office of the Director of Area Mental Health Services 26 January 2012.

[9] Director of Mental Health's Consideration of the Findings of an Inquiry Under Section 95 of the Mental Health (Compulsory Assessment and Treatment) Act 1992.
http://img.scoop.co.nz/media/pdfs/1206/S95_DOMH_Opinion__Final.pdf

decisions or failed to take action to address the situation have not been held individually accountable.

The NZMA acknowledges that other quality and safety mechanisms exist in the health sector and that these continue to evolve, helping to enhance safety and health outcomes for patients and the standard of health services generally. We do not believe however that quality assurance through these mechanisms, which are generally at a systems level, will ever be a surrogate for direct regulation of the individual.

Level of Risk

The section on 'safety' in the discussion document also asks whether the HPCA Act is clear about the level of risk that needs be to be regulated by statute.

The HPCA Act refers to the provision of mechanisms for protecting the public from health practitioners who practise below the required standard of competence or who are unable to perform the required functions of the role. Certain activities can be restricted to particular health practitioners where the Minister is satisfied that members of the public risk serious or permanent harm if the activity is performed by persons other than health practitioners who are permitted by their scopes of practice to perform that activity. The likely risk of harm is also a deciding factor as to whether other, currently unregulated, health services are designated health professions and brought in under the Act.

While 'risk of harm' is not defined under the Act the Medical Council has developed the following criteria:

Risk of harm may be indicated by:

- a pattern of practice over a period of time that suggests the doctor's practice of medicine may not meet the required standard of competence; or
- a single incident that demonstrates a significant departure from accepted standards of medical practice; or
- recognised poor performance where local interventions have failed - this does not exclude notification of serious concerns where internal review or audit is inaccessible or unavailable to the person with the concern; or criminal offending; or
- professional isolation with declining standards that become apparent.

Risk of serious harm may be indicated when:

- an individual patient may be seriously harmed by the doctor; or
- the doctor may pose a continued threat to more than one patient and as such the harm is collectively considered 'serious'; or
- there is sufficient evidence to suggest that the alleged criminal offending is of such a nature that the doctor poses a risk of serious harm to one or more members of the public.

The NZMA does not believe there is a need to define the level of risk that needs to be regulated by statute. There is sufficient scope within the HPCA Act to control the level of risk being regulated against, both in the principles set down in Section 13 and in the Minister's ability to audit and be satisfied that regulation is required and that the nature or degree of regulation is commensurate to risk.

Attempting to further define the level of risk that needs to be regulated under the statute would limit the Minister's consideration of these matters on a case by case basis, the flexibility that needs to exist within a rapidly changing sector and the ability of RAs to intervene.

3. Discussion Document – operational matters

As previously noted the 2008/09 review of the HPCA Act culminated in 37 recommendations for legislative and operational improvements. Of these 37 recommendations only 6 have been implemented in full while the remainder either require ongoing action, or are currently under consideration or awaiting legislative amendment[10].

If these matters had been progressed in a more timely fashion it is possible that some of the perceived shortcomings of the current system would have been mitigated. In particular the implementation of Recommendation 12 to develop a set of indicators to measure the effectiveness of the HPCA Act and the performance of RAs would have enabled a more informed review of the policy settings for professional regulation than this discussion document offers. Instead the Ministry's response as to what progress has been made to date in relation to Recommendation 12 was that developing a set of indicators was considered during the development of the common reporting template for RA annual reports but no further action has been taken since then.

Cost of regulation

No analysis of costs has been provided in the discussion document nor any attempt made to assess costs verses benefits. A statement is however made that the type of statutory regulation currently in the HPCA Act is considered an expensive way to ensure the public are safe from harm when accessing services but this is unsubstantiated and no comparators showing cost differentials are provided.

While the NZMA acknowledges that compliance with the HPCA Act involves both direct and indirect workforce and health system costs it is impossible to judge value for money in the absence of information and analysis. We agree however that RAs must consider cost impact on individuals, employers and ultimately consumers and tax payers when considering scope of activities and resourcing requirements (RAs work on a cost recovery basis). This consideration must however be balanced against ensuring that standards are maintained, processes are fair and comprehensive and that public safety and confidence is assured.

While the question of whether we can afford to maintain a robustly regulated workforce is valid it is equally valid to ask whether we can afford not to. In the case of the medical profession we believe that regulation is being administered under the principle that the practice of a profession will only be restricted where benefits of restriction outweigh the costs.

[10] Information released under the Official Information Act 1982 by the Ministry of Health to the New Zealand Medical Council September 2012.

The NZMA is aware that work is underway to seek efficiencies and cost saving through the sharing of RA secretariat and office functions. While it is appropriate to consider ways of reducing costs in this way it is imperative that any changes to existing RA structures do not in any way diminish the capacity of each RA to regulate its professional group and ensure public health and safety.

As noted previously, regulatory processes affect the livelihood and practice of every health practitioner. It is therefore critical that registration bodies are responsive to individual registrant's needs and circumstance. Services are best delivered by those with intimate knowledge of the profession they are working with and who can relate to and understand the particular needs of that health professional group.

The NZMA outlined its concerns regarding this proposal in our submission to Health Workforce New Zealand dated 11 April 2011 and our support remains limited to options of streamlining back-office functions where there is a clear demarcation between generic administration functions and regulatory activities.

Data collection

The NZMA agrees that workforce data is essential for workforce analysis and planning and we support RA collected data being made available for this purpose. Issues of privacy can be dealt with by the provision of only non-identifiable data and matters of common definitions and standardisation should be able to be resolved.

Improved data collection and reporting into a centralised repository may however require initial investment and an ongoing increase in costs for some RAs which may increase fees if not directly funded. These costs therefore need to balanced against the benefits of data collection in the same way that it is suggested that regulation be weighed against costs more generally.

Consumer involvement

The primary interest consumers have in professional regulation relates to safety so that they can have confidence that those providing health services are appropriately qualified and are competent in their area of practice. Consumers also want to be assured that action is taken to address individuals whose practice is below standard and if necessary their practice is curtailed.

Improving public understanding of the HPCA Act is challenging as often there is little desire to seek out this information until something untoward happens within the health professional / patient relationship. Consumers will otherwise assume that both the professions and the government will have the appropriate checks and measures in place.

The NZMA believes further improvements to public understanding of health professional regulation in New Zealand could be achieved alongside improved health literacy generally. This would be best coordinated nationally by the Ministry of Health and would require ongoing investment in educational and social marketing strategies.

The concept of a consumer forum in New Zealand that would provide a platform for consumer input is something that should be explored. Ideally this would not be limited to this particular area and could facilitate consumer involvement across the health sector as

has been the experience across the Tasman with the establishment and successful operation of the Community Health Forum of Australia.

The discussion document also asks whether we have the balance of laypeople and health professionals on RA boards. While this is an important question we would however caution against confusing lay representation with consumer input. Lay appointees to boards will of course bring their own perspectives as consumers to the table, hopefully along with governance skills and experience. These individuals may not however be representative of consumer views and therefore the need for other avenues of consumer input remain.

While the presence of lay appointees to RA boards and councils is fully supported, the NZMA believes that RAs need to remain professionally-led as per our opening statement in this submission. As such we endorse the Medical Council structure of four laypersons, four doctors elected by the profession and four doctors appointed by the Minister of Health.

Pastoral care

It is a function of RA to consider the cases of health practitioners who may be unable to perform the functions required for the practice of the profession. This may ultimately mean a determination to restrict practice or suspend or cancel registration.

Mixing this core role with a requirement for RAs to provide care for health professionals as is suggested in the discussion document is challenging and could be counterproductive. On one hand patient safety may be compromised as the RA attempt to work with the health professional to identify and resolve the matters affecting practice and on the other hand knowing that the entity that provides pastoral care also has the ability to remove you from practice could be a barrier to seeking support.

The Medical Council does provide support services to health professionals needing assistance but in managing the "unwell doctor" the Council's Health Committee will typically impose restrictions and/or requirements and as a consequence under-reporting does exist.

In order to fulfil their primary purpose RAs will always need to protect public safety first and care for the doctor second. As such it would be better to separate the roles of legal enforcement and pastoral care.

The NZMA is currently developing a position statement on doctors' health, wellbeing and vitality and would support the establishment of an independent service that is professionally run and appropriately resourced providing support for health professionals. This could operate on a confidential basis to encourage self reporting but with the requirement to report to the appropriate RA any individuals whose practice is sufficiently impaired to constitute risk to patients. The NZMA also suggests that workforce wellness and wellbeing be acknowledged as a quality indicator for health services generally and a performance measure for DHBs.

Regulatory options

The NZMA supports the principle of regulation commensurate with risk. When considering which professions should come under the auspices of the HPCA Act, those who could be regulated using an alternative model, and those who do not require statutory regulation, assessment of risk must be the primary factor.

To this end, Section 116 of the HPCA Act allows the Minister to make a determination in the regard based on the risk of harm to the public or matters otherwise in the public interest.

We share Government's concerns about the increasing number of health provider groups seeking to be recognised as a profession and regulated under the HPCA Act and the potential proliferation of RAs being created for these new groups. The NZMA is also concerned regulation under the same statute that regulates doctors can serve to give these practitioners, their methods of treatment and the products they use, legitimacy and credence that they otherwise would not have had.

The NZMA has previously suggested of a two tier system of regulation, the first being the current system to cover those professions where there is potential for significant harm and the second being a lesser licensing system that covered those professions where there was the potential for some harm but at a lower level. This would provide a mechanism to regulate where there is some risk of harm but in a way that does not add significantly to the overall cost of regulation and avoids undue standing being conferred.