New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

29 March 2018

Health Committee
Select Committee Services
Parliament Buildings
WELLINGTON 6160

By email: health@parliament.govt.nz

**Health Practitioners Competence Assurance Amendment Bill**

Dear Sir/Madam

The New Zealand Medical Association (NZMA) wishes to provide feedback on the above Bill.

1. The NZMA is New Zealand's largest medical organisation, with more than 5,000 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our members, Advisory Councils and Board.

2. We continue 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.

3. We understand the Bill arises from reviews of the Health Practitioners Competence Assurance Act 2003 (the Act) conducted in 2009 and 2012. We are pleased to note that the legislative amendments that are being proposed in this Bill generally represent improvements to the existing framework rather than a move away from the current regulatory model. We consider most of the amendments to be sound and likely to lead to the removal of some of the current barriers to improved process, and the provision of better and expedited information to the public and the profession. Nevertheless, we have concerns with some of the amendments in the Bill that we believe are outside the scope of the Act, not feasible to implement, have detrimental consequences or require further clarification. We elaborate on our feedback on specific sections in the Bill in the paragraphs below.


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**Section 49 amended (Power to order medical examination)**

4. We note that 'a medical practitioner' is replaced with 'an assessor' who can be any health practitioner, not just a medical practitioner, and that 'medical examination' is amended to 'examination or testing.' This could mean a doctor is sent for examination to a nurse or allied health practitioner. We are concerned by these amendments as there is no detail about how an assessor is selected or the process for determining the appropriateness of the assessor. Until these details are specified and considered, we are unable to support these amendments.

**Section 93 amended (Interim suspension of registration or imposition of restrictions on practice)**

5. We note that this amendment allows for immediate suspension of registration where there is a risk of serious harm to the public, without having to give notice of intention to suspend. We support this amendment and believe it rectifies the anomaly in the current Act which does not allow a responsible authority to suspend a practitioner immediately even though there is a serious risk of harm to the public.

**Section 102 amended (Orders limiting restoration of registration)**

6. We note that this amendment sets a minimum time period within which a deregistered practitioner may not reapply for registration. This amendment does not appear to relate to the public safety aspect of the Act unlike other requirements in this section which specify education / counselling / treatment, etc, to address the matter that gave rise to the cancellation of the person's registration. Its only purpose seems to be punitive, and as such, it could be beyond the scope and aims of the Act.

**Section 103A Resourcing Tribunal's administration costs**

7. We note that this amendment introduces a new funding arrangement that requires responsible authorities to pay the Health Practitioners Disciplinary Tribunal an annual amount towards general administration costs that is determined by the number of health practitioners registered within the authority. We have concerns about how equitable this new funding arrangement would be, given the very large number of registered practitioners in some responsible authorities (eg, nursing) and the fact that some responsible authorities have a considerable proportion of registered practitioners that do not have annual practicing certificates. Given that the funding is for the Tribunal's administration costs, a more equitable alternative might be to require all responsible authorities to pay the same annual contribution towards administration costs.

**Section 116 Amalgamation of authorities**

8. We note that these amendments allow the Minister to amalgamate existing responsible authorities. Our main concerns are that decisions to amalgamate may be influenced by the desire for cost savings, and that patient protections specific to a professional group could be compromised through an amalgamation process. These concerns are partly mitigated by the proposed requirement to consult the authorities before amalgamation, and to be satisfied that such amalgamation is in the public interest.

**Section 116D Members not entitled to compensation for loss of office**

9. We note that this amendment proposes that no member of a responsible authority is entitled to any compensation for loss of office resulting from amalgamation. It appears designed purely to limit Crown expenditure. It has been suggested that this amendment may contravene existing employee rights and employer obligations under other legislation. We suggest that it would be useful to provide clarification on this point.

**Section 118 amended (Functions of authorities to promote and facilitate inter-disciplinary collaboration)**

10. We note that an amendment "to promote and facilitate inter-disciplinary collaboration and co-operation in the delivery of health services" is proposed. While teamwork is a laudable aim in its own right, we question the feasibility and value of trying to legislate for inter-disciplinary collaboration in legislation that is primarily about protecting the public by the licensing of individuals and ensuring their competence, conduct and fitness to practice. Teamwork already sits (along with cultural safety and a host of other competencies) under professionalism and professional conduct which the existing legislation covers. We do not believe that inter-disciplinary collaboration and co-operation should be separated out and specified in this legislation. Accordingly, we seek the revocation of this amendment.

**Section 122A Performance reviews of authorities**

11. We note that the Bill introduces the requirement for performance reviews of responsible authorities. While the concept of performance reviews is sound in principle, we have concerns that the proposed amendments are very open ended and lack detail about objectives, performance criteria, assessment methodology, and consequences if responsible authorities are found to be lacking in any area. Of particular concern is that responsible authorities do not appear to have any ability to challenge or respond to the review and must immediately publish the report. Unlike in some other jurisdictions, New Zealand does not have an overarching independent body to oversee and regulate the responsible authorities. We note that the amendments put the Ministry of Health in charge of this process although they must appoint an independent person to conduct the review. We submit that an overarching body should be fully independent and have powers to back up its findings.

12. We note that the proposal also tasks the Ministry of Health to set the terms of reference for each review. To ensure a level playing field for all responsible authorities, we submit that it would be better to use a common set of principles that inform reviews of all responsible authorities. We also seek clarification on who determines the specific performances measures that would be used, and how to ensure that these will not be influenced by political or workforce priorities. For example, a valid performance measure could be the average length of time to license a non-New Zealand trained practitioner. While there may be good grounds for this process to take an extended period in many cases, there could be political and sector drivers to speed this process up.

**Section 134A Authority to provide to Director-General of Health information about health practitioners**

13. We note that these amendments relate to the mandatory provision of workforce data by responsible authorities to the Ministry of Health for the purposes of workforce planning and development. We note that the information to be provided includes a health practitioner's name, date of birth, employer, places of work, and average weekly hours worked at each place of work. We do not support these amendments for a number of reasons. Collection of workforce data does not fit within the purpose of the Act. The amendments would place an obligation on responsible authorities without providing any empowering provisions, including provisions for funding this activity. In addition, these amendments appear to breach practitioners' rights to privacy.

14. Currently, the Medical Council collects workforce data as part of Annual Practicing Certificate applications, but it is not mandatory to provide this. Health Workforce New Zealand (HWNZ) provides the Medical Council with the questions it would like answered and the Council then provides this information in a nonidentifiable fashion without divulging the raw data. Rather than enact mandatory information collection and sharing under the HPCAA (including the requirement for information to be disclosed in an identifiable form), we suggest that matters

relating to workforce data and analysis be addressed by improving the contracts between HWNZ and responsible authorities.

**Section 157 Naming policies**

15. We note that amendments in this section relate to a new naming policy that sets out the principles and criteria under which a health practitioner may be named publicly. We are supportive of these principles and criteria. We note that the Bill also proposes that naming policies are consulted on and reviewed every 3 years. We are supportive of these requirements.

**Mandatory referral to a Professional Conduct Committee**

16. An issue raised in the 2009 and 2012 reviews of the Act but not addressed in the current Bill relates to the requirement for a responsible authority to refer a practitioner to a Professional Conduct Committee (PCC) if that health practitioner is convicted of a wide range of offences. While such referral is necessary and appropriate in cases of serious criminal offending, we believe that the threshold for mandatory referral needs to be higher. Currently, referral is required in cases involving minor substance abuse offending such as drink driving. We suggest that clear guidelines be developed to allow responsible authorities discretion to refer minor one-off offences involving substance abuse to a health process, rather than mandating an automatic referral of such cases to a PCC.

We hope that our feedback has been helpful. We would like the opportunity for an oral hearing to speak to our submission.

Yours sincerely

Dr Kate Baddock
NZMA Chair