Briefing

Improving health workforce regulatory settings – changes for consultation

Date due to MO:	16 May 2024	**Action required by:**	23 May 2024
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To:	Hon Dr Shane Reti, Minister of Health		
Copy to:	Hon David Seymour, Associate Minister of Health Hon Matt Doocey, Associate Minister of Health Hon Casey Costello, Associate Minister of Health		
Consulted:	Health New Zealand: ☒ Māori Health Authority: ☐		

Contact for telephone discussion

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Minister's office to complete:

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☐ See Minister's Notes	☐ Withdrawn	

Comment:

Improving health workforce regulatory settings – changes for consultation

Security level:	IN CONFIDENCE	**Date:**	16 May 2024
To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This briefing outlines the significant changes proposed to include in a consultation document on a new direction for health workforce regulatory settings.

Summary

2. The review of health workforce regulatory settings has identified the need for significant change, particularly to the Health Practitioners Competence Assurance Act 2003 (the HPCA Act).

3. In previous advice we have:

   a. identified the key challenges present in the regulatory system that are limiting access to quality health services [H2023032966]

   b. developed objectives that represent the necessary shifts for health workforce regulation [H2024037463].

4. To address these challenges, and progress towards the agreed objectives, we recommend three significant changes to health workforce regulation, which are:

   i. utilise the full competence of our workforce through responsive scopes of practice

   ii. establish alternative forms of regulation commensurate to risk to public safety

   iii. an accountable and efficient structure to support modern regulation.

5. To achieve these changes, we are exploring a range of options which we propose to consult with the public on in August-October 2024.

6. In this briefing, we have outlined and compared the options that could be considered to achieve each regulatory change (**Appendix 1**). We have also clearly indicated our preferred options that, in our view, will provide the most benefit to the health workforce and the public.

7. Following your confirmation of the changes and options for consultation, the Ministry will provide you with a draft Cabinet paper and consultation document for Cabinet's approval in July 2024.

Recommendations

We recommend you:

a)	**Note** that the changes outlined in this briefing are proposals for public consultation, we will provide you with policy decisions following consultation	**Noted**
b)	**Note** that these changes are intended to shift health workforce regulation to be people-centred, right-touch, and sustainable	**Noted**
c)	**Agree** to the Ministry drafting a public consultation document on options for significant changes to health workforce regulatory settings	**Yes/No**
d)	**Note** for each change we have indicated preferred options	**Noted**
e)	**Discuss** with Ministry officials any of these changes, preferred options and any additional changes you would like to see considered in the consultation document	**Yes/No**
f)	**Note** that you will be provided with a draft Cabinet paper in July 2024, seeking approval to begin public consultation on these changes in August 2024.	**Noted**

Maree Roberts
Deputy Director-General
Strategy Policy and Legislation
Date: 16 May 2024

Hon Dr Shane Reti
Minister of Health
Date:

Improving health workforce regulatory settings – changes for consultation

Background

1. The Ministry has undertaken a review of health workforce regulatory settings to explore changes that may be necessary to improve workforce flexibility and provide for a sustainable workforce that can meet New Zealand's growing health needs.

2. While the HPCA Act has contributed to high-quality and competent health practitioners, the current framework reinforces entrenched professional silos that do not encourage collaboration and innovation within our workforce.

3. The design of health workforce regulation, and the decisions made by regulators, have a direct impact on workforce supply and can either facilitate or hinder a flexible, responsive, and sustainable health workforce.

4. The HPCA Act was amended in 2019 after two previous reviews, completed in 2009 and 2012. The amendments focused on addressing operational issues and sought to improve collaboration among responsible authorities (RAs) within the current framework.

5. However long-standing issues persist, which will require a significant shift to address and provide for regulation that enables access to health services through increased flexibility, while upholding high standards of patient safety. To achieve this shift will require health workforce legislation with a new purpose and a more cohesive regulatory structure.

Reform outcomes and objectives

6. You were briefed previously on the proposed approach regarding the review of health workforce regulatory settings, and the key challenges present in the regulatory system that have arisen, either directly or indirectly, from the implementation of the HPCA Act [H2023032966 refers].

7. In March 2024, you agreed to the following objectives that will provide a framework for regulatory reform [H2024037463 refers]:

    a. People-centred regulation: High-quality regulation where community needs are paramount.

    b. Right-touch regulation: Regulation that is proportionate to the level of risk posed to public safety.

    c. Sustainable regulation: Regulation that can be implemented through lasting and efficient processes and structures.

8. The changes for consultation outlined in this briefing represent the more significant regulatory changes that we recommend testing with health workforce stakeholders, and the public, in pursuit of these objectives.

Consultation process

9. A key objective of the proposed shifts is to deliver a regulatory framework that delivers improved access to health services for consumers. As such, it will be valuable to allow

the wider public the opportunity to engage at this early stage to provide consumer feedback on the larger shifts. A wide public consultation will provide an opportunity to improve and refine the proposed changes and reveal any unintended consequences.

10. Given the significant interest in the proposed changes from certain key stakeholders such as RAs and professional bodies, targeted engagement will also be required through the consultation process. This engagement will inform the detailed design of the proposal to ensure successful implementation of the changes.

11. The changes outlined in this briefing will form the basis of a consultation document to be released, pending approval from Cabinet, in July 2024. This document will describe the new direction for health workforce regulation, our aspirations for the health workforce, and the proposed policy changes to inform new legislation.

Changes to improve health workforce regulatory settings

12. We consider that the desired shift can be achieved through three broad changes:

    a. utilise the full competence of our workforce through responsive scopes of practice

    b. establish alternative forms of regulation commensurate to risk to public safety

    c. an accountable and efficient structure to support modern regulation.

13. These changes will provide for legislation focused on driving increased levels of patient safety through ensuring practitioner competence and enabling service flexibility.

14. The proposed options have been assessed against the agreed objectives outlined in the review to improve regulatory settings (**Appendix 1**).

Change 1: Utilise the full competence of our workforce through responsive scopes of practice

15. To meet the health needs of our communities, we need regulatory settings that empower the workforce to develop and utilise their skills to the greatest extent possible, and to deliver team-based models of care. Innovative and flexible approaches to regulation will increase the accessibility, productivity and responsiveness of our health workforce, which will lead to better health outcomes for all New Zealanders.

16. Restrictive scopes of practice, professional silos, and limited pathways to demonstrate competence are preventing health practitioners from working to their full capability, creating inefficiencies that manifest in limited access and reduced quality of care.

17. Providers of health services need improved access to a broad range of skills and capabilities to address workforce challenges and meet consumer health needs. The global experience during the COVID-19 pandemic demonstrated the need–and ability–to regulate scopes of practice in a more dynamic way that enables greater flexibility in determining skill mix, role definition and redefinition, task sharing and task shifting, and fosters inter-professional collaboration and team-based models of care.

18. The HPCA Act authorises profession-based regulators (RAs) to describe a scope of practice in any way it thinks fit within broad parameters, creating inconsistencies across professions. While scopes of practice generally state the qualifications required for an individual to be considered a fit-and-proper practitioner of a profession, it is often less clear – particularly to a layperson – the services a practitioner is competent to provide.

Proposals to deliver consistently applied scopes of practice that recognise individual practitioner competence

19. We have identified two preferred, related proposals to the health system's approach to scopes of practice, outlined below. In addition to these proposals, we considered a prescriptive approach of including reserved practice provisions in legislation (e.g. conferring the rights of particular professions to make diagnoses, prescribe, etc.). While this would provide more clarity to scopes of practice, it would impose rigidities on the health workforce that would hamper innovation and responsiveness.

Specifying and upholding principles for professional scopes of practice in the Act

20. We propose to consult on developing a new set of principles regarding professional scopes of practice, so that they are aligned with system and community needs.

21. We propose to develop principles that will ensure scopes of practice:

    a. are designed to recognise the full competence of a practitioner

    b. identify shared areas of skills and capabilities between professions

    c. provide the flexibility for practitioners to build competencies outside their scope

    d. provide a clear description of the competencies within the scope of that profession.

22. Providing greater clarity in scopes of practice with regards to the competencies a health practitioner is permitted to perform, would create opportunities to improve the efficiency of how a service provider can utilise their workforce to meet health needs. There are also opportunities for improved long-term workforce planning and commissioning while assuring safety.

23. Broad and unclear scopes make it difficult for commissioners to confidently identify appropriate health providers for their customers. Greater clarity of practitioner competence will enable commissioners of services, such as ACC and HNZ, to purchase health services more efficiently.

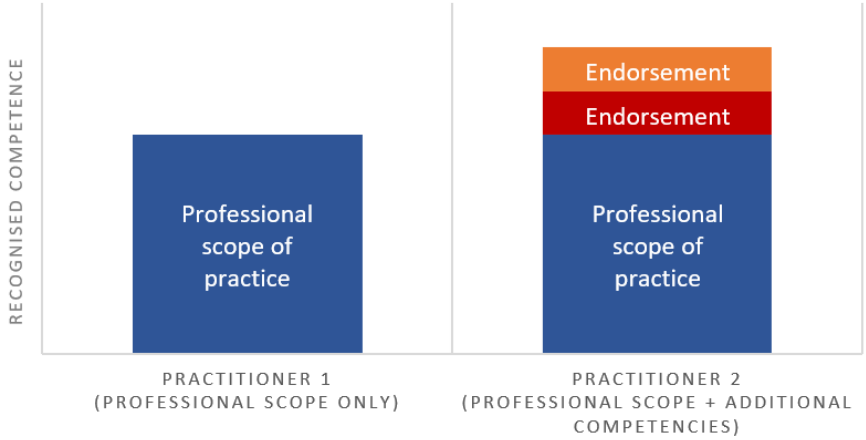
Developing individual scopes of practice

24. While professional scopes of practice are an important tool to identify and assure the quality of the services a practitioner provides, such standardisation and rigidity does not recognise the full range of competencies an individual practitioner may develop throughout their career. A regulatory system that provides multiple avenues to recognise the full competence of our workforce, including robust and proportionate quality assurance processes, would increase the productivity, responsiveness, availability, and accessibility of the health workforce while still maintaining a high level of safety.

25. Literature suggests that decisions about individual scopes of practice are often best made at the local level via formal credentialling, or between employer and employee rather than through centralised regulatory control. This would allow the practitioner to hold a bespoke scope of practice, taking into consideration their qualifications, skills and competencies, experiences, the facilities and supports available, and any upskilling they may have undertaken via continuing professional development (CPD) or on-the-job training, to enable them to meet the specific needs of their local community.

26. We propose to consult on an approach to individual scopes of practice, whereby a practitioner's baseline scope of practice would be their professional scope, and they would be empowered to broaden their skillset through formal recognition of additional competencies. These additional competencies would be endorsed and recognised in their individual scope of practice (**Figure 1**).

FIGURE 1: INDIVIDUAL SCOPES OF PRACTICE



27. Several international regulators, including in Australia and the United States, have developed frameworks to assist the local decision-making process, and we would provide similar guidance. These processes would be developed in consultation with interested stakeholders to ensure they were satisfied with the level of quality assurance.

28. This builds on and formalises the current approach already underway in the nursing profession, where registered nurses are empowered to take responsibility for health care activities or roles that could be considered outside their professional scope. Nurses can develop their level of expertise through postgraduate education and experience, and work with their employer to recognise those increased competencies.

Benefits and opportunities of proposal

Consumers

29. Alignment of scopes across professions will improve the availability of services designed to meet specific community needs.

30. Enabling greater recognition of competence, such as through more efficient upskilling, can significantly increase consumer access to services through increasing capacity and diversity of services and a providing greater consumer choice.

Practitioners

31. Clarifying professional competencies will identify the 'shared spaces' (where practitioners from multiple professions are considered competent) and the unique specialties across each profession, which will support the delivery of multidisciplinary care.

32. Enabling service providers to recognise the competence of their workforce more efficiently, will reduce the burden on professions currently in high demand. For example, consumers may be more willing to see a sufficiently competent nurse practitioner instead of waiting for a GP.

Service providers

33. Individual scopes of practice will provide more flexibility for health service providers to design models of care that can the needs of their consumers, and enable them to maximise the potential of their workforce.

34. Formalising local recognition processes would enable the embedding of proportionate levels of assurance to maintain service quality and patient safety.

35. Individual scopes of practice and local recognition of practitioner competence provides means for the health system to be more responsive to local need and orient towards protecting and upholding people's physical, psychological, social, and cultural safety. It would provide more flexibility to support the planning, commissioning, and funding of the right skill mixes to meet local needs.

Equity

36. Clear and consistent scopes will improve the understanding of workforce capability, which can support better commissioning and workforce planning. This can enable the effective delivery of health services to historically underserved populations.

37. Formal recognition of skills by at a local level will allow employers of regulated health workers to respond to local needs more easily, such as prioritising culturally safe health services and reducing health inequities.

Risks and implications

38. Successful implementation of this new approach to scopes of practice would require further shifts in education and training and employment settings, such as micro-credentialling and staircasing, which the Ministry is progressing as part of its health workforce strategic policy work programme. The proposed legislative changes would create a regulatory environment that enables and encourages professional development in response to local health needs.

39. Inserting principles into the legislation to guide the development of scopes of practice is not sufficient to guarantee a change from professional regulators. It is our view that there is significant risk that the intended benefits of these changes will not be realised without addressing the accountability issues outlined in **Change 3**.

Recommendation: Agree to consult on the above changes to utilise the full competence of our workforce through responsive scopes of practice.	**Yes / No**

Change 2: Establish alternative forms of regulation commensurate to risk to public safety

40. Under the HPCA Act, there is only one form of regulation. This binary approach does not reflect the diversity of services (and associated risks) provided across the health system. Consequently, some occupational groups may be regulated by an RA when other, less restrictive and expensive regulatory models may provide sufficient public protection.

41. Having a single approach to regulating health practitioners has led to perverse incentives for professions to seek statutory regulation when it may not be necessary to

ensure a satisfactory level of safety. A profession may seek to become regulated under the Act to attain a higher level of status in the eyes of consumers, to protect their professional titles, or to ensure easier access to public funding (such as through ACC).

42. While there are few studies that examine the effectiveness of alternatives to statutory registration, studies from the grey literature suggest regulatory models such as negative licensing (in Australia and the United States) and accredited registers (in the United Kingdom and Hong Kong) have a role to play as part of a broader health workforce regulatory regime, to improve the quality of health services and protect consumers.

Proposal to establish an Accredited Register system for low-risk health practitioners

43. Our preferred option is to establish a 'second tier' of regulated health professions, similar to the Accredited Registers programme that is managed by the Professional Standards Authority (PSA) in the United Kingdom.

44. Accredited Registers are voluntary registers that set standards for practitioners working in unregulated health and care occupations. In the United Kingdom, organisations that hold Accredited Registers must meet clear governance, management, and operational standards to provide a level of quality assurance for professions not requiring statutory regulation.

45. The Accredited Registers would be endorsed by the workforce regulator(s) to set and uphold standards of their respective professions. The workforce regulator(s) would also have the authority to audit the Accredited Register to maintain regulatory quality.

46. This proposed approach would also provide an opportunity to revisit the definition of a health practitioner in the HPCA Act, which is currently limited to practitioners registered with an RA. This definition has a range of implications outside the scope of the HPCA Act, including access to funding through ACC and employment law.

47. We will further engage with agencies that use the current definition beyond the scope of the Act, such as ACC and HNZ, to understand the breadth of these implications.

48. We have also considered other forms of regulation that could provide a less burdensome alternative to statutory regulation, such as negative licensing.[1] While an Accredited Register model is our preferred option, we will seek feedback on these other forms of regulation through the consultation.

Benefits and opportunities of proposal

Consumers

49. According to the UK PSA, Accredited Registers help people make informed choices about receiving lower-risk health services by ensuring that the practitioners are competent and trustworthy. This consumer benefit creates an incentive for practitioners to join their respective register to advertise and verify their competence and safety.

50. Accredited Registers can provide pathways for funding of unregulated professions. This can empower consumers to make their own choices about managing their health needs.

[1] Negative licensing is a more 'reactive' type of regulation, where practitioners are not required to be registered but face sanction if they breach standards or codes.

Practitioners

51. Establishing additional mechanisms to assure quality of a profession will ensure concerns (such as title protection) can be addressed without imposing unnecessary regulatory burden. There is an opportunity to relieve the burden on professions who might currently be overregulated.

52. Accredited Registers can provide unregulated professions with pathways to access public health funding for a greater variety of services.

53. Increased quality assurance of unregulated professions, such as through an Accredited Register, will improve consumer awareness of the profession and confidence in the quality of services they can provide.

Service providers

54. An intermediate level of regulation may provide a mechanism to resolve regulatory threshold questions such as the regulation of assistant professions like physician associates and midwifery assistants. This proportionate level of regulation will provide employers greater flexibility to utilise these professions and assurance that the workforce they hire is of a certain quality.

Equity

55. There is an opportunity with alternative forms of regulation, like an Accredited Register, to develop formal recognition pathways for the vocational skills (such as vaccinating) of kaiāwhina and the community workforce, which could help address issues of inequitable care and workforce shortages.

Risks and implications

56. The implementation of an Accredited Register system should be designed to minimise the additional financial burden on currently unregulated workers, including on their respective peak bodies. We anticipate that a peak body applying to be endorsed as an Accredited Register would come at a cost. As such, we will consider potential mitigations and/or incentives so that becoming or joining an Accredited Register is considered worthwhile by the professional bodies and practitioners.

57. There is a risk that professions subject to an intermediate level of regulation will be viewed as less than those that are fully regulated. As such, this shift would need to be supported by public messaging that regulation is based on the risk profiles of professions and is not a judgement on a profession's value or legitimacy.

58. An agency will be required to manage and oversee an Accredited Register. This would most effectively be done through a single regulatory entity, as described in **Change 3**, otherwise an existing agency would need to take responsibility for this function.

Recommendation: Agree to consult on the above change to establish alternative forms of regulation commensurate to risk to public safety.	**Yes / No**

Change 3: An accountable and efficient regulatory structure

59. As the range of health services continues to expand, with developments in technology, models of care, and multi-disciplinary health teams providing specialised support for a variety of patient needs, there is additional complexity for regulators to ensure health services are delivered safely and efficiently.

60. In New Zealand, and many other jurisdictions, profession-based regulators do not have the incentives, resources, or capabilities to consider how their activities and decisions affect the health system. This limits their ability to respond to workforce challenges.

61. Under the HPCA Act, RAs are independent statutory bodies. The primary responsibility and accountability for the regulation of health practitioners falls on the relevant RA. This separation from the Executive is intentional, to prevent undue influence over decisions.

62. The HPCA Act does provide the Minister of Health some powers to ensure RAs comply with legislation, including the authority to appoint board members, facilitate disputes between RAs, and recommend to Cabinet that boards be amalgamated. These powers are disproportionate and reactive, so therefore mostly ineffective in providing system direction and accountability.

63. Over several decades, successive regulatory reviews, principally from Canada, the United Kingdom and Australia, have recommended greater government oversight and the removal of professional representation as an organising principle of regulators. This level of oversight must be balanced with the need to retain the independence of decision-making required for a regulator to perform its role.

64. The independent review of Australia's regulatory settings pertaining to overseas health practitioners stated that regulators need to consider how they can:

    a. work with governments and other regulators to monitor, plan for, and implement changes to their regulatory approaches and practices to respond to evolving health care demands; and

    b. improve efficiency, minimise duplication, and harmonise activities with other regulators to achieve better regulatory outcomes.

65. This level of connectedness was envisioned when the HPCA Act was enacted, with flexible regulation and cross-profession collaboration key outcomes. However, the implementation of the Act has not met this intent.

Options for addressing accountability and efficiency

1. Amalgamating RAs into a single regulatory body (preferred option)

66. Under this option, the 18 RAs would be amalgamated into a single regulatory body, which would be responsible for the entire regulated health workforce.

67. The existing structure of 18 RAs that independently regulate their own professions does not support the coordinated approach necessary to deliver regulation that fully enables interdisciplinary, team-based models of care.

68. Establishing the body as a Crown entity would provide the Minister of Health (and the Ministry) the levers needed to ensure responsive and high-performing regulator.

2. Providing additional levers for the Ministry of Health under the HPCA Act

69. If we do not proceed with a Crown entity model, we could establish the Ministry as responsible for managing, monitoring, overseeing, and directing the RAs under the HPCA Act. This option could provide the Minister of Health additional levers, through the Ministry, to provide strategic direction to the RAs.

70. Historically, it has been challenging for the Ministry to fulfil its system stewardship function as this is not explicitly provided for within the HPCA Act. As a result, the Ministry has limited levers to influence and support RAs.

71. This would not address the fragmentation and accountability issues of the current structure as the RAs would remain independent, profession-based statutory bodies.

3. Establishing an administrative service

72. An administrative service could be established within the Ministry of Health to support the active stewardship function that is lacking in the current regulatory structure.

73. This would facilitate proactive and collaborative regulation among RAs, streamline registration processes, and ensure consideration of patient voice in regulatory decisions.

74. While an administrative service could support a more sustainable regulatory model, it would not necessarily provide more accountability to government. It would also uphold professional silos, and thus be likely to have a minimal impact on system fragmentation.

4. Reducing the number of RAs

75. This option proposes reducing the number of RAs by amalgamating (under section 116A of the HPCA Act) some of the smaller RAs and/or by transitioning lower-risk professions to an accredited register (see **Change 2**) if deemed appropriate.

76. It is difficult for a country as small as New Zealand to justify 18 independent regulators. Reducing the number of RAs would increase system efficiency, sustainability and cross-profession collaboration, but would not address accountability issues.

77. While this option does not require legislative change, it would still be worthwhile including in consultation.

Preferred option: Amalgamate RAs into a single regulatory body

78. To keep pace with the increasing complexity of health needs, and to provide coordination and quality assurance of regulation, many jurisdictions have established oversight agencies that provide a range of support functions for regulators and consumers. In line with this international trend, we propose to amalgamate the 18 RAs and to establish a Health Workforce Regulatory Agency (HWRA).

79. This would simplify the regulatory structure, enable consistency across the health system, and provide for greater economies of scale in operating costs. It would also provide the opportunity to streamline registration pathways, with consistent registration requirements and processes for overseas practitioners.

We propose the new agency be established as a Crown entity

80. We propose consulting on establishing the HWRA as a Crown entity (either as a Crown agent or autonomous Crown entity) under section 7 of the Crown Entities Act 2004.

81. Since the regulatory structure under the HPCA Act was established, the Crown Entities Act 2004 has been enacted to provide a consistent framework and structural model when it is recognised that a government function (such as workforce regulation) should be carried out at 'arm's length' from the government. We did consider whether this new entity could be established as a branded business unit within the Ministry of Health, but this would not provide appropriate separation between the regulator and government.

82. Regulatory bodies are commonly established as Crown entities (e.g. Social Workers Registration Board, Real Estate Authority). We propose the current regulatory functions of RAs be retained by the HWRA. These functions include:

    a. setting standards of clinical, cultural and ethical conduct

    b. registering practitioners

    c. managing complaints and concerns about professional conduct

    d. monitoring and accrediting educational institutions

    e. promoting and facilitating inter-disciplinary collaboration health service delivery.

83. Crown entities retain an appropriate level of independence to perform their functions, however the Minister assumes responsibility for overseeing and managing the performance of the entity. The Minister's roles include:

    a. appointing and maintaining an effective governance board

    b. providing the Crown entity board with clear performance expectations

    c. setting the direction of the Crown entity

    d. monitoring and reviewing operations and performance

    e. managing risks on behalf of the Crown.

84. This change would necessitate the dismantling of the 18 existing RAs, through an amalgamation into a single entity and board. Through this transition, it would be beneficial to make efforts to maintain the vital skills, relationships, knowledge, and capability that these organisations possess. Much of this technical and clinical capability will be necessary to advise the new HWRA to deliver on its functions.

85. We propose to seek views on funding arrangements that would adequately resource the new regulatory structure while also addressing equity and sustainability concerns raised by some RAs during initial consultation [H2024037463 refers]. The Ministry will consider initial costing options for the HWRA.

Benefits of preferred option

Consumers

86. A single, public-facing agency for consumers to find information on the health workforce, and a simplified pathway to raise complaints or other disciplinary issues.

Practitioners

87. Streamlining registration and Annual Practising Certificate (APC) processes will remove duplication and align evidentiary requirements for overseas practitioners.

88. The simpler structure will provide more efficient use of funds, which will allow APC fees to be set more equitably.

Health system

89. The increase in oversight of the Crown entities model will provide the Minister with the ability to set the direction of workforce regulation. This reflects a system approach to decision-making and patient safety, ensuring regulation is developed to meet future health needs while retaining appropriate independence for the regulator.

90. A single agency responsible for practitioner registration offers an opportunity for consistent workforce data collection. This would provide a more accurate picture of workforce composition, distribution, attrition and gaps, which can be used to better inform workforce planning, investment and commissioning.

91. The expected efficiencies gained with a single regulator would result in improved use of public funds and accountability over how it is used.

Equity

92. With the improved accountability of a Crown entity model, the Minister will be able to set clear expectations for the new regulator to embody the Government's good-faith and collaborative approach to Māori Crown relationships.

93. There will also be an opportunity to consistently apply and enforce standards of cultural capability across all health professions, which is particularly important for Māori and other cultural minority groups.

Delivering on coalition agreement

94. The current coalition agreement between the National Party and the ACT Party commits to improving recognition of overseas medical qualifications and experience, including the "consideration of an occupations tribunal".

95. We understand that the intent of an occupations tribunal in the context of health workforce regulation would be to provide a mechanism to review decisions made by regulators, particularly regarding individual registration applications from overseas workers. Establishing a new Crown entity will provide the opportunity for additional levers for the Minister of Health to address concerns about regulatory decisions.

Risks and implications

96. We expect that the efficiencies of the proposed option would result in a more cost-effective structure over time with better use of public funds. However, establishing a new Crown entity will likely require significant upfront funding for the Crown.

97. The proposal of a single regulator will likely be contentious given entrenched views toward the concept of independent professional regulation. We are developing an engagement plan to manage stakeholder concerns and enable their valuable input into the development and implementation of any changes.

Recommendation: Agree to consult on the above changes to create an accountable and efficient regulatory structure.	**Yes / No**

s 9(2)(f)(iv)

Next steps

101. The Ministry will provide you with a draft consultation document and draft Cabinet paper for your review in July 2024.

102. We will also provide you with a draft consultation plan for your approval.

ENDS.

Appendix 1: Change options analysis

Change 1: Utilise the full competence of our workforce through responsive scopes of practice			
Option	**People-centred regulation**	**Right-touch regulation**	**Sustainable regulation**
Status quo	**--** Restrictive scopes of practice and narrow view of competence limits practitioners' ability to provide health services, reducing patient access.	**--** Current settings are disproportionate to the level of risk and do not consider patient safety implications of lack of access.	**-** Overly restrictive scopes of practice limit the sustainability of the health workforce.
Scopes prescribed in HPCA Act	**+** Prescribing scopes of practice in legislation would provide more clarity on which professions are permitted to provide specific services.	**--** Legislation is a blunt instrument to assure quality of practice and will not be commensurate to risk.	**--** Impose further rigidity on the workforce and impede ability for the system to adapt to changing needs.
Scopes principles embedded in HPCA Act (preferred)	**+** Clearly define intent and expectations regarding scopes of practice and the development and recognition of competence.	**+** Can enable a more proportionate approach to competence recognition and development. Full implementation dependent on structural changes.	**+** A principles-based approach allows for more flexible implementation to apply the principles to emerging contexts.
Individual scopes of practice (preferred)	**+** More ways to demonstrate and recognise an individual's competence would increase availability of services.	**++** A high-trust and well-supported recognition system would provide proportionate risk management.	**+** More recognition pathways allow for greater adaptability and responsiveness to community needs.
Change 2: Establish alternative forms of regulation commensurate to risk to public safety			
Option	**People-centred regulation**	**Right-touch regulation**	**Sustainable regulation**
Status quo	**-** Limited accountability and quality assurance for unregulated workforce.	**--** Burdens some professions and risks unsuitable practitioners providing services.	**-** Rigid binary approach is less adaptable to emerging health needs.

Accredited registers (preferred)	**+** Associations holding accredited registers would be accountable for professional standards, etc. of its members.	**++** Provides more proportionate quality assurance for currently regulated professions that may not carry high risk, and currently unregulated professions in which there is risk.	**+** Provides a more adaptable option to assure quality of new and emerging services. Capacity to deliver dependent on structural changes.
Negative licensing	**-** Reactive mechanism means limited accountability and quality assurance.	**+** Provides a mechanism for setting standards across a profession without requiring registration.	**++** Minimal resource required to maintain and easy to change as required.
Change 3: An accountable and efficient regulatory structure			
Option	**People-centred regulation**	**Right-touch regulation**	**Sustainable regulation**
Status quo	**--** Structure entrenches professional silos; minimal RA accountability.	**0** Structure reflects binary regulatory approach established in HPCA Act.	**--** Difficulties for smaller RAs to fulfil regulatory functions, including financial sustainability concerns. Currently slow to adapt, including to new professions.
Administrative service	**+** May promote cross-RA collaboration; minimal accountability change.	**0** Minimal change from status quo.	**+** Support RAs to fulfil functions. Minimal effect on adaptability.
RA amalgamation	**+** Amalgamating RAs to create cross-profession regulators would reduce some professional silos. Amalgamation alone would not improve RA accountability.	**0** Minimal change from status quo.	**+** Amalgamation would increase financial sustainability of smaller RAs and their ability to fulfil their functions under the Act.
Single Crown entity (preferred)	**++** Crown entity model provides improved accountability mechanisms. A single entity removes structural professional silos and ensures necessary clinical input.	**0** Minimal change from status quo.	**++** A cross-profession Crown entity will provide for greater operational efficiency and adaptability to emerging health needs (e.g. new professions).

Minister’s Notes