Briefing

Review of Health Workforce Regulatory Settings – Outcomes and Objectives

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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☐ See Minister's Notes	☐ Withdrawn	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:

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To:	Hon Dr Shane Reti, Minister of Health		

Purpose of report

1. This briefing provides you with the proposed outcomes and objectives for the review of health workforce regulatory settings (including the Health Practitioners Competence Assurance (HPCA) Act 2003). These outcomes and objectives are intended to support you in identifying the most effective improvements to the HPCA Act and the health workforce regulatory system.

Summary

2. Following your confirmation in December 2023, the Ministry of Health | Manatū Hauora (the Ministry) has been continuing the review of health workforce regulation, including the HPCA Act.
3. The initial phase of the review involved engagement with stakeholders to identify the key challenges present in the regulatory system that is limiting accessibility of quality health services [H2023032966 refers]. These challenges have arisen directly or indirectly from the regulatory system established through the HPCA Act.
4. To respond to these challenges, we have developed objectives that represent the necessary shifts for health workforce regulation. Identifying review objectives provides for a more future-focused and cohesive approach to addressing system challenges, compared to a challenge-centred consultation, which can be backwards-looking and lead to a fragmented patchwork of outcomes.
5. We recommend three objectives for the review: people-centred regulation; right-touch regulation; and sustainable regulation.
6. These objectives build on and modernise the initial intent of the HPCA Act, which included enabling flexible regulation and promoting cross-profession collaboration.
7. For each objective, we have identified outcomes that will guide decisions on what action is required to correct the shortcomings evident in the current system and ensure the objectives are met.
8. Our intention is for these outcomes and objectives to inform the options we propose for legislative change. We will brief you in April 2024 on legislative change options for public consultation.

Recommendations

We recommend you:

a) **Confirm** the proposed objectives and associated outcomes of the review of health workforce regulatory settings **Yes/No**

b) **Note** that officials will brief you in April 2024 on legislative change options for public consultation. **Noted**

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

Hon Dr Shane Reti
Minister of Health
Date:

Review of Health Workforce Regulatory Settings – Outcomes and Objectives

Background

9. You were briefed previously on the health workforce programme and the proposed approach regarding the review of the Health Practitioners Competence Assurance Act 2003 (the HPCA Act) [H2023032584 and H2023032966 refer].

10. You agreed to the Ministry developing and consulting on fundamental changes to health workforce regulation, and to the Ministry drafting a public consultation document on a new direction for health workforce regulation [H2023032966 refers].

11. Through this briefing, we seek your agreement on the objectives and outcomes of the review to deliver a future regulatory system that will enable greater access to timely and high-quality services.

Review of health workforce regulation

12. The HPCA Act provides a framework for the regulation of health practitioners to ensure they are fit and competent to practise their professions. This regulatory framework, and its implementation, has a significant impact on the availability, accessibility, responsiveness, productivity, and quality of the health workforce.

13. Much of our health workforce is regulated under the HPCA Act. Under this Act, Responsible Authorities (RAs) for each profession oversee registration of practitioners, set scopes of practice, accredit education and training providers, and define professional standards.

14. Our ongoing review of health workforce regulatory settings has found that they are not enabling the development of a flexible, sustainable and diverse health workforce that is set up to meet the needs of all people in New Zealand.

15. Workforce regulation is a key enabler for the other system shifts that are needed to address the challenges the health workforce is facing, particularly across education and employment settings. The Ministry is intending to consult on a new approach to health workforce regulation with a more cohesive regulatory structure.

Current state challenges

16. The initial phase of the review involved engagement with stakeholders to identify the key challenges present in the regulatory system that is limiting accessibility of quality health services [H2023032966 refers]. We have summarised the challenges as follows:

    a. **Narrow interpretation of safety:** The current regulatory settings do not consider the risk to patient safety posed by health services being unavailable or inaccessible. There are also inconsistent approaches to elements of safety beyond physical or mental harm, such as social and cultural safety. Current settings place the burden of patient safety heavily on the competence of practitioners rather than recognising safety as the responsibility of the entire regulatory system (of which practitioner competence is one part).

b. **Disproportionate regulation:** The current system offers only a binary approach to regulation. "Right-touch" regulation – such as a tiered approach based on risk – would help maintain quality, while improving availability and accessibility.

c. **Embedded professional silos:** Regulating the workforce by profession produces social and professional incentives to raise regulatory barriers over time.

d. **Regulatory inefficiencies:** RAs are largely reliant on practitioner fees to fund their activities, which has led to financial sustainability issues for some smaller regulators. Lack of resource inhibits innovation and improvement in regulation.

17. These challenges have arisen directly or indirectly from the regulatory system established through the HPCA Act. It is an enabling piece of legislation that places significant responsibility in the hands of profession-based regulators. But this has enabled undesirable decision-making that reinforces an outdated approach to safety and entrenches professional silos, leading to disproportionate and inefficient regulatory settings. As such, significant legislative change is required to ensure that regulatory settings enable and empower the health workforce to deliver on community needs.

Reform objectives and outcomes

18. Identifying review objectives provides for a more future-focused and cohesive approach to addressing system challenges, compared to a challenge-centred consultation, which can be backwards-looking and lead to a fragmented patchwork of outcomes.

19. According to the World Health Organization (WHO) Western Pacific Region, "a well-designed regulatory system should: not create unnecessary burdens, for example, financial and administrative; should be focused on risks to public safety, proportionate to potential benefits; and should be sufficiently flexible to work effective for different healthcare needs and approaches, and regard future changes."[1]

20. To achieve this, and in response to the identified challenges, we recommend three objectives for the review:

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.

21. These objectives build on and modernise the initial intent of the HPCA Act. The intent of the HPCA Act was to enable flexible regulation and promote cross-profession collaboration, such as complementary scopes of practice for practitioners. But implementation has not met intent due the challenges identified above. For each objective, we have identified several outcomes that will guide decisions on what action is required to correct the shortcomings evident in the current system and ensure objectives are met.

[1] WHO WPR. Western Pacific regional action agenda on regulatory strengthening, convergence and cooperation for medicines and the health workforce. *World Health Organ West Pac Reg*. Published online 2019:1-96.

Objective 1: People-centred regulation

22. The primary purpose of regulation is to protect people; therefore, they should be at the centre of the regulatory system and decisions. Structuring the regulatory system around professions has led to unintended practices, perverse incentives of "patch protection," and limited transparency and accountability.

23. People-centred regulation will refocus our health workforce regulatory settings on patient needs and safety, including cultural safety, team-based models of care and accessibility to services. This requires system-wide and cross-profession coordination, scopes of practice being designed in line with service provision and stronger accountability mechanisms to ensure a high-quality workforce that meets patient needs.

Outcome 1.1: Regulatory decisions consistent with community health needs

24. RAs are subject to a range of perverse incentives when it comes to effective public regulation in the interests of the community. Because they are split by profession and are predominantly governed by members of that profession, there are social and professional incentives to adopt profession-friendly regulations (e.g. around cultural safety); limit transferability of learning to other professions (i.e. "patch protection"); and to raise regulatory barriers over time (e.g. academic inflation).

25. For example, the Nursing Council of New Zealand requires students to complete 1,100 hours of clinical experience to become a Registered Nurse, compared to 800 in Australia.

26. Academic literature on health regulatory best practice raises concerns about the risk of 'regulatory capture' under governance arrangements where regulatory bodies comprise mostly elected members of the regulated profession.

27. A recent review of regulatory settings in British Columbia, Canada, found that its profession-based model of regulation was inefficient; had enabled cultures that sometimes promoted the interests of professions over those of the public; was not keeping up with the changing health service delivery environment, particularly in relation to interprofessional team-based care; nor meeting changing patient and family expectations regarding transparency and accountability. Deficiencies in the governance of professional colleges and a lack of transparency have allowed for the promotion of interests of the professions over those of the public, compromising public trust.[2]

28. Through engagement in 2023, the Ministry heard similar concerns about profession-based regulators in New Zealand. RAs have limited regard to wider health system needs. They often undertake their roles in isolation of health system stakeholders that depend on their decisions, such as employers, education providers and patients.

29. Over several decades, successive regulatory reviews, principally in Canada, the UK and Australia, have recommended removal of 'representativeness' from the governance of regulators and greater government oversight, to mitigate these risks. Establishing cross-profession levers to provide strategic direction to regulatory bodies will allow for decision-making that takes a system/people-centred approach.

[2] BC Steering Committee on Modernization of Health Professional Regulation. Recommendations to modernize the provincial health profession regulatory framework. Published online August 2020.

Outcome 1.2: Service design should inform the development of scopes of practice and enable practitioners to work to their full capability

30. Practitioners in New Zealand can be restricted from providing services in which they are otherwise competent as these are not within their scope of practice. A review of this approach could allow for greater flexibility across the workforce and improve access, particularly for rural communities, by permitting more practitioners with the required skills and capabilities to provide more general, low-risk services.

31. Optimising the scopes of practice of health practitioners can facilitate multidisciplinary and complementary teams. Inefficiencies occur when health practitioners are not able to work to their full capability accorded by their education, training, experience and competence. These inefficiencies may manifest as higher costs and more limited access to health care and concerns about quality and safety.

32. There is strong evidence that jurisdictions with more flexible scope of practice regulation for nurse practitioners achieve higher supply, improved access and better health outcomes for patients, especially in rural and underserved areas.[3][4][5] While this flexibility is possible under current regulatory settings, patch protection and siloed decision making continues to influence the design of scopes and employer decisions.

33. The preferred approach to the regulation of risky treatments and activities (those that are judged to be so risky that only qualified workers should be authorised to carry them out) is one which enables various cadres of health workers to be authorised based on demonstrated competencies rather than which occupation they belong to.

34. Literature suggests that the workforce reform effort required to achieve and maintain an optimal skill mix in the health workforce is and should be core business for governments.

35. Currently, the services a practitioner is allowed to provide under their scope of practice can be unclear, which has implications for commissioning and workforce planning. Ensuring that scopes of practice clearly state the services a practitioner is competent to provide, which overlap across professions and are designed in line with service provision, will enable more efficient and accurate commissioning and planning.

Outcome 1.3: Greater system accountability

36. The 2019 amendments to the HPCA Act sought to provide for greater system accountability by introducing performance reviews and other measures.

37. Researchers have identified a raft of accountability measures or oversight mechanisms that apply to regulators, such as: independent review processes, whole of government regulatory management systems and scrutiny by multiple integrity agencies (judicial review of regulator decisions, ombudsman laws, anti-corruption and whistle-blower protection laws).

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[3] Odell E, Kippenbrock T, Buron W, Narcisse MR. *Gaps in the primary care of rural and underserved populations: the impact of nurse practitioners in four Mississippi Delta states*. J Am Assoc Nurse Pract. 2013;25(12):659-666.

[4] Smith T, McNeil K, Mitchell R, Boyle B, Ries N. *A study of macro-, meso- and micro-barriers and enablers affecting extended scopes of practice: the case of rural nurse practitioners in Australia*. BMC Nurs. 2019;18(1):N.PAG-N.PAG.

[5] Xue Y, Kannan V, Greener E, et al. *Full Scope-of-Practice Regulation Is Associated With Higher Supply of Nurse Practitioners in Rural and Primary Care Health Professional Shortage Counties*. J Nurs Regul. 2018;8(4).

38. In the UK, the Professional Standards Authority (PSA) has the authority to review decisions made by the regulators regarding practitioners' fitness to practice, including the option to appeal to the High Court if it considers decisions to be insufficient for the protection of the public. Similarly, Ontario, Canada recently established tribunals external to the regulator to hear disciplinary matters.

39. Currently, the only accountability mechanisms available in New Zealand to government (including you as the Minister) are reactive and severe. We propose the review consider more proactive and proportionate accountability mechanisms to address risks before they become issues or manage accountabilities more appropriately (including consideration of an occupations tribunal).

Objective 2: Right-touch regulation

40. Regulators worldwide are implementing various quality assurance models and alternatives to statutory regulation in attempts to find the "right touch." Our current binary system causes issues at both ends of the spectrum of risk: some high-risk tasks can be undertaken by individuals not competent, while otherwise competent practitioners are prevented from providing low-risk services. Our system also provides perverse incentives for professions to seek to be regulated under the HPCA Act beyond patient safety, such as access to funding. A multi-tiered system provides right-touch profession regulation that provides for safe delivery of services, while a right-touch approach to scopes of practice would recognise a practitioner's competence outside their profession's scope.

Outcome 2.1: Regulatory system proportionate to risk to public safety

41. Our current regulatory system offers only a binary approach to regulation. This approach does not reflect the diversity of services provided by professions regulated under the HPCA Act. Consequently, some occupational groups may be licensed when other regulatory models (such as negative licensing[6] or co-regulation) may provide sufficient public protection.

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 USA) and accredited registers (in the UK 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 better protect consumers.

43. The tools of risk-based regulation are being used by some regulators internationally to better target regulatory interventions, weighing risk to the public with the need to improve access to health services, particularly for underserved populations. For the assistant and support workforce, lower-cost models of quality assurance (for example, co-regulation, negative licensing or accredited register) may be sufficient. It is for these reasons we propose that an outcome of this review be that our regulatory system is proportionate to the level of risk posed to public safety.

[6] 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.

Outcome 2.2: Broaden means to demonstrate competence

44. In our current regulatory system, a practitioner's competence is assessed largely on their formal qualifications. As important as this is to determine baseline standards, there are few mechanisms or incentives to upskill or stack competencies beyond a professional scope of practice (see Outcome 1.2). This prevents optimal utilisation of the skills and capabilities of our health workforce by not enabling practitioners to work to their full capability or to build new competencies in response to local or emerging needs.

45. The 2024 WHO-commissioned review of global health practitioner regulation systems noted the importance of providing various means to recognise a practitioner's competence, and thus their individual scope of practice.[7] It found that the preferred approach to determining an individual health practitioner's scope of practice is through a local process of credentialing within the health facility, where a range of factors may be considered, including the practitioner's qualifications, skills and competencies, the facilities and supports available, any upskilling they may have undertaken via continuing professional development (CPD) or on-the-job training and the health needs of the population served.

46. This would enable our workforce to be more responsive to local or system needs. An example that demonstrates the potential for our health system to be adaptable to meet health needs is the establishment of the Vaccinating Health Worker (VHW) role during the COVID-19 pandemic.

47. This allowed health workers such as kaiāwhina, pharmacy technicians, and overseas registered health workers to deliver COVID-19 vaccines under supervision. In turn, it enabled us to vaccinate New Zealanders quickly and effectively, and helped provide more opportunities for more Māori and Pasifika vaccinators to support their communities.

48. We want to see this responsiveness built into the design of our regulatory system by providing more means to demonstrate and recognise competence, which would also enable appropriately skilled and qualified health professionals to take on primary care tasks to reduce pressure on general practitioners. This shift in the regulatory system would enable progress across other policy levers, such as education pathways and commissioning, to deliver this change.

Objective 3: Sustainable regulation

49. To be sustainable, a regulatory system needs to be fit-for-purpose not just now but into the future. In our current system, we expect all regulators to carry out the same functions despite significant differences in size, complexity, and risk (RAs range from 474 registrants to 77,000, and from one scope of practice to 45). These size discrepancies flow through into matters of financial sustainability, which has been raised as a concern by smaller RAs and limits their capacity for regulatory innovation and best practice. At the same time, larger RAs carry a heavier administrative burden, for example, registering larger numbers of internationally trained practitioners.

[7] Health Practitioner Regulation Systems (who.int)

Outcome 3.1: Transition to a more sustainable regulatory model

50. RAs are reliant on practitioner fees to fund their activities, which has led to financial sustainability issues for some smaller regulators. Some RAs have expressed to us concerns of the "one-size-fits-all" approach to RA functions and expectations, rather than basing these on RA revenue, size or risk profile. They have also raised equity concerns regarding high registration fees for lower paid (often female-dominated) professions.

51. For some regulators, a significant proportion of funds needs to be held in reserve for disciplinary activity that may be required. This inhibits innovation and improvement in areas such as processing times of registration applications or investment in IT or other services.

52. We propose that the review considers options for a more sustainable regulatory model to address current-state concerns raised by RAs and set the system up to succeed adapting to emerging needs in the future.

Next steps

53. The Ministry will brief you in April 2024 on options for legislative change to achieve the objectives of the review, for public consultation.

54. Following that, the Ministry will draft a public consultation document and engagement plan for your review in May.

55. You will be briefed separately on actions the Ministry will take to strengthen its system stewardship function to make improvements to workforce regulatory settings under the existing HPCA Act.

ENDS.

Minister’s Notes