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12 December 2024

s 9(2)(a)

Ref: H2024053431

Tēnā koe s 9(2)(a)

Response to your request for official information

Thank you for your request under the Official Information Act 1982 (the Act) to the Ministry of Health – Manatū Hauora (the Ministry) on 9 October 2024 for information regarding the Health Practitioners Competence Assurance Act 2003 (HPCA Act). You requested:

> *"…documents held by the Ministry of Health concerning the review of the Health Practitioners Competence Assurance Act 2003. I'm seeking reports and other documents covering matters including the aims and purposes of the review, the plans for how the review will be conducted, lists of parties consulted, summaries of consultation, material received from the Medical Council of New Zealand, Nursing Council of New Zealand, Paramedic Council, and the Physician Associate Society of New Zealand, identification of issues, discussion of options, timeframes, and email and other correspondence with ministers."*

The Ministry has identified 30 documents to be within scope of your request. All documents are itemised in Appendix 1 and copies of the documents are enclosed. Where information is withheld under section 9 of the Act, I have considered the countervailing public interest in release in making this decision and consider that it does not outweigh the need to withhold at this time.

Please note the following briefings below have been withheld in full under section 9(2)(f)(iv) of the Act, to maintain the constitutional conventions that protect the confidentiality of advice tendered by Ministers and officials.

- Briefing: Improving accountability and decision-making of health workforce regulators (H2024048465)
- Briefing for decision: Expedited path for future of health workforce regulatory settings (H2024051486)

In addition to the enclosed documents, four briefings to the Minister of Health are within scope of your request have been proactively released on the Ministry's website at: www.health.govt.nz/information-releases/health-workforce.

The Ministry has provided a list of stakeholders with whom we have engaged or sought to engage to date. For engagements where there was a record of discussion or written feedback provided by a stakeholder, we have provided these in our response to you. With regard to meeting minutes and discussion summaries, please note the following:

- Discussion summaries (documents 14,15,23,25,27 and 28) note key points raised by at least one participant in the discussion. They do not necessarily reflect the positions of all participants and should not be taken as such.
- Attendees have advised the items titled '*Meeting minutes*' (documents 4,16 and 20) are more informal records of conversation and that there is typically no formal process to edit or approve these notes. As such, we would recommend providing a named organisation the opportunity to clarify or correct the record, should you wish to attribute a position to them.

The Ministry has also provided relevant items in the Weekly Reports to the Minister. You will note that the Weekly Reports from 8 August 2024 (document 13) onward include a RAG status. Please be advised that these refer to the status of a wider work programme, which includes the review of the HPCA Act, and are not the status of the review only.

Finally, please note that timeframes have evolved over the course of the project, and that some timeframes advised earlier in the year are no longer accurate.

I trust this information fulfils your request. If you wish to discuss any aspect of your request with us, including this decision, please feel free to contact the OIA Services Team on: oiagr@health.govt.nz.

Under section 28(3) of the Act, you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: info@ombudsman.parliament.nz or by calling 0800 802 602.

Please note that this response, with your personal details removed, may be published on the Manatū Hauora website at: www.health.govt.nz/about-ministry/information-releases/responses-official-information-act-requests.

Nāku noa, nā

Maree Roberts
Deputy Director-General
Strategy Policy and Legislation | Te Pou Rautaki

Appendix 1: List of documents for release

#	Date	Document details	Decision on release
1	4 April 2024	Weekly Report item: Health workforce	Some information withheld under section 9(2)(a) of the Act to protect the privacy of natural persons.
2	30 May 2024	Weekly Report item: Health workforce	Some information withheld under section 9(2)(a) and deemed out of scope.
3	6 June 2024	Weekly Report item: Health workforce	
4	11 June 2024	Meeting minutes: Self-Regulating Professions hui #11	
5	13 June 2024	Weekly Report item: Health workforce	
6	26 June 2024	Weekly Report item: Health workforce	
7	4 July 2024	Weekly Report item: Health workforce	
8	11 July 2024	Weekly Report item: Health workforce	
9	18 July 2024	Weekly Report item: Health workforce	
10	25 July 2024	Weekly Report item: Health workforce	
11	July 2024	PowerPoint: Future of Health Workforce Regulation	Some information withheld under section 9(2)(f)(iv) of the Act to maintain the constitutional conventions that protect the confidentiality of advice tendered by Ministers and officials.
12	1 August 2024	Weekly Report item: Health workforce	Some information withheld under section 9(2)(a) and deemed out of scope.
13	8 August 2024	Weekly Report item: Health workforce	Some information withheld under the following sections of the Act: • 9(2)(a); and • 9(2)(f)(iv) Some information deemed out of scope.
14	19 August 2024	Hauora Taiwhenua Rural Health Network	Released in full.
15	20 August 2024	Summary – Professional Associations	Some information withheld under section 9(2)(a) of the Act.

#	Date	Document details	Decision on release
16		Meeting minutes: Allied Health Responsible Authorities Group	Some information withheld under the following sections of the Act: • 9(2)(a); and • 9(2)(f)(iv) Some information deemed out of scope.
17	21 August 2024	Weekly Report item: Health workforce	Some information withheld under section 9(2)(a) and deemed out of scope.
18	26 August 2024	Weekly Report item: Health workforce	
19	5 September 2024	Weekly Report item: Health workforce	Some information withheld under section 9(2)(a) and deemed out of scope.
20	10 September 2024	Meeting minutes: Self-regulating professions hui	Some information withheld under the following sections of the Act: • 9(2)(a); and • 9(2)(f)(iv) Some information deemed out of scope.
21	12 September 2024	Weekly Report item: Health workforce	Some information withheld under section 9(2)(a) and deemed out of scope.
22	19 September 2024	Weekly Report item: Health workforce	Some information withheld under the following sections of the Act: • 9(2)(a); and • 9(2)(f)(iv) Some information deemed out of scope.
23	20-23 September 2024	Email correspondence: Feedback on Proposed Changes to Health Workforce Regulation – NZAPH's Perspective	Some information withheld under section 9(2)(a) and deemed out of scope.
24	26 September 2024	Weekly Report item: Health workforce	Some information withheld under section 9(2)(a) and deemed out of scope.
25	2 October 2024	Collective of Health Responsible Authorities feedback	Released in full.
26	3 October 2024	Weekly Report item: Health workforce	Some information withheld under section 9(2)(a) and deemed out of scope.
27	2024	Future of Health Workforce Regulation discussion document: New Zealand Association of Medical Herbalists	Released in full.

#	Date	Document details	Decision on release
28		Summary of RA workshops	Some information withheld under section 9(2)(a) of the Act.
29		Stakeholder engagement list	Released in full.
30		Future of Health Workforce Regulation	

Document 1

Weekly Report for week commencing 8 April 2024, prepared on 4 April 2024

1.4 Health workforce

Review of health workforce regulatory settings

We are preparing an options analysis of proposed changes to health workforce regulatory settings, including the Health Practitioners Competence Assurance Act 2003, which we intend to provide you by the end of April 2024. We will circulate a first draft to Health New Zealand – Te Whatu Ora and other relevant agencies in the week commencing 8 April 2024 for comment.

Ministry conversations are ongoing to progress a work programme on our approach to active stewardship of the health workforce regulatory system and deliver improvements within current legislative settings.

Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a)

Document 2

Weekly report for week Commencing 3 June, prepared 30 May

1.4 Health workforce

This item updates you on work to review health workforce regulatory settings Out of Scope

Review of health workforce regulatory settings

As requested, we will provide you with Use Cases by mid-June 2024 so you can see the how the proposed changes may impact health service delivery.

We are now working on an engagement plan so that we can start to further develop the options with trusted stakeholders.

Out of Scope

Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a)

1.4 Health workforce

This item updates you on Out of Scope, and work to review health workforce regulatory settings and the physician associate role.

Out of Scope

Review of health workforce regulatory settings

Following your request, we will provide you with end use cases by mid-June 2024 so you can see how proposed changes may affect health service delivery. We are working across the Ministry and Health NZ to develop a range of end use cases as they relate to different professions and consumers, including how a proposed new regulatory system would interact with rongoā Māori.

We are now working on an engagement plan so that we can start to further develop the options with trusted stakeholders.

Out of Scope

Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a)

Document 4

Minutes

Self-Regulating Professions hui #11

Date:	11 June 2024
Time:	1.00 pm – 2.20 pm
Location:	Microsoft Teams
Chair:	Lauren Hancock
Attendees:	S9(2)(a) [redacted] Martin Chadwick, S9(2)(a) [redacted] Caitlin Yeoman (minutes)
Apologies:	S9(2)(a) [redacted]

Item	Notes
Out of Scope	[redacted]

Out of Scope

[redacted]

2	Review of the HPCA • Jay Andrews, Principal Analyst in the Regulatory Policy team is part of the team that is working to review the Health Practitioners Competence Assurance Act (HPCA Act), as well as the broader workforce regulatory settings. • While you are not under the HPCA Act, you are still an important part of the health system. • Last year the team ran some targeted consultation with members of the health workforce to gain some understanding of the way the HPCA Act is being operationalised – understanding the current state and the challenges as well as the opportunities for improvement in how we deliver health services particularly in relation to how we regulate the health workforce. • There are three broad principles that we hope to achieve in the future of the regulatory system: o For regulation to be people-centred: patient safety focussed, rather than recognition of a profession. o Right touch regulation: ensuring the regulation we have is commensurate to the level of risk to the public. Not all professions have the same level of risk. Jay acknowledged self-regulation and that it isn't considered as part of the HPCA Act. o Regulation needs to be able to adapt and evolve as health needs change. • The HPCA Act is 21 years old, and the framing goes back to the 1995 legislation for doctors – 30 years on it doesn't reflect the way health services are provided and we need to consider this as well as how they will be delivered in the future. • Jay and his team want to ensure that the consultation process is transparent and that this is an open conversation and dialogue looking at different ways of regulation (such as those overseas). Discussion: • Clinical Physiologists Registration Board (CPRB):

[1] The Hauora Haumi Allied Health Report was published on 27 June 2024 and can be found here: https://www.health.govt.nz/publication/hauora-haumi-allied-health-report-2024

- The CPRB chose to withdraw their application to be regulated under the HPCA Act. There is a high cost to become regulated, with very little protection for the public. They felt penalised by the fact that physiologists worked well and couldn't provide great statements of harm – they could only provide international evidence.
- The CPRB felt that the HPCA Act only really protected the name, and they felt better sticking with self regulation.
- They originally decided to apply for regulation under the HPCA Act because there was a lack of understanding and knowledge from other health professions. There were multiple instances of regulated colleagues saying they were dangerous because they weren't regulated.
- Being self-regulated has allowed the CPRB to be more agile – if the Board want to make changes, they just do it. If they were under the HPCA Act everything would have to be gazetted.

- New Zealand Sterile Services Association (NZSSA):
  - Before S9(2)(a) became lead for the NZSSA, they raised funds to apply to be regulated under the HPCA Act, but then legislation changed, and they were left out.
  - The NZSSA feel that they should be regulated as a profession with high risk. Sterilising technicians' roles impact patients' risk of infection during surgery.
  - NZSSA have had issues with people saying that they don't have to listen to them as they don't have authority, and it puts the NZSSA in a difficult situation. S9(2)(a) wanted Jay to know this so that he and his team can understand the role of the professions when they undertake this work.
- New Zealand Association of Medical Herbalists (NZAMH):
  - NZAMH's application to be regulated under the HPCA Act was successful in 2004, but the new government in 2007 withdrew their application.
  - They have been trying for over 15 years to become regulated via the HPCA as there is no other avenue. It has been painful and costly.
  - The HPCA is not necessarily appropriate for a profession such as medical herbalism, but they are a profession where patients can come to harm, particularly when a "practitioner" who has only done a weekend course in herbal medicine is treating people and saying that they're a medical herbalist.
    - There is no way to differentiate someone like the above with an NZAMH member who has had 3-4 years training fulltime under NZQA training courses. This distinction is important from a patient safety perspective – need to know when it is ok to treat someone, and when they need to be referred on.
    - Medical herbalists could make a better contribution if there was a better regulatory set up.
  - Jay is open to other views and experiences about how to get to right touch proportional regulation. There is a consumer protection element as well – visibility for consumers to know that the person they are seeing is competent. While we are identifying areas for improvement, we do want to acknowledge that there are good things about the current system that we do want to keep. This isn't a comment or criticism on what anyone is doing now.
  - S9(2)(a) reiterated that the HPCA Act has become a hindrance to delivering services – it's about trying to get people well safely. Medical herbalists do not receive any funding, so if a patient can't pay

to see them, they miss out. There are people being escalated to secondary and tertiary care when something could have been very cheaply addressed early on.

- New Zealand Audiological Society (NZAS):
  - S9(2)(a) asked about how to subscribe to updates on regulation.
    - There is no specific newsletter, but Jay suggested his team could link into Martin's regular newsletter.
  - The bulk of audiologists do not work in Te Whatu Ora, so the issues are different. S9(2)(a) encourages consultation with NZAS as regulation is a hot topic within the society – a very vocal cohort would like NZAS to apply for registration. Is it worthwhile now, or better to wait?
    - We do not want to pre-suppose what will happen as the review is still underway. Jay suggested that we can put S9(2)(a) in touch with the right team offline as no one on this call is qualified to give that advice.
  - The biggest challenges are not being recognised in legislation and COVID really highlighted that.
  - NZAS have recognition through the Ministry of Health Hearing Services funding – it specifies that audiologists have to be a member of NZAS to access the funding. ACC are also helpful, but there are parts of ACC legislation that effectively restrict our members' scopes because they are not regulated under the HPCA Act.
  - The Health and Disability code of rights and Commission is also under review – is there an opportunity to make it easier or faster for people to make complaints and then get them addressed, to provide a better safety mechanism for organisations like us?
    - Jay confirmed that his team do engage with the HDC on this work.
- New Zealand Association of Counsellors (NZAC):
  - Our organisation offers a lot of value to our members and the communities our members serve, through professional development and ethics processes. It was quite clear that if we pursued HPCA regulation, our members would pay for it, but they would not be able to pay for the association alongside it. HPCA regulation would mean the end of our Association.
  - Full statutory regulation is an expensive task. Do associations struggle to get members to join, or is considered part of the job to join? For our members to get ACC funding they need to be a member of one of two organisations for counsellors in New Zealand (NZAC being one of them).
- Hospital Play Specialists Association of Aotearoa | New Zealand (HPSAANZ):
  - HPSAANZ are a very small association with less than 100 members so anything with a cost is out of the question.
  - There is no obligation for Te Whatu Ora to employ registered Hospital Play Specialists, so no recognition. It is desirable to hire someone registered, but it is not a requirement (this is the same for other self-regulated professions, with a lot of difference across employment settings too).
  - We keep talking about risk, but what about showcasing excellence and the value of our professions?
- New Zealand Orthoptic Society (NZOSI):
  - Very small profession of only 36 people. Given we are one of the smallest self-regulated professions, we cannot afford to go down the HPCA Act route. Due to the cost, the NZOSI would be interested to

	see other options available. S9(2)(a) suggested a self-accreditation process. o Biggest drive to become regulated is to receive ACC funding, which we cannot currently receive because we are not regulated under the HPCA. Patients are going to lesser-trained professionals who are regulated under the HPCA Act to have treatment that is counterproductive because they don't have the option. o Echoing what others have said, having an awareness of how orthoptics are different to ophthalmology and optometry colleagues, is important – very different expertise. Having more of a voice, more of a presence is our driving factor. o This work can only have so much influence on ACC's decisions and processes, but Jay A confirmed that the policy team continue to work with them. • Allied Health Aotearoa New Zealand: o S9(2)(a) pointed out that there's a lot of inequality in funding even among allied health professionals. She suggested that AHANZ needs to be consulted because not all members are represented in the self-regulated professions group. o To fully understand the needs, strengths, abilities, capacity of everyone, you need to have more information. o There is also a limitation around education levels provided nationally in New Zealand. • Martin acknowledged Jay for coming along today. Please be fair in so far that we are trying to make sure that we are keeping you fully informed and have brought Jay along as a sense of this is beginning to shape up. There will be a consultation process and there will be the opportunity to feed into it. o Jay found this helpful and thanked everyone for their comments and questions. o Lauren thanked Jay for coming.
Out of Scope	[redacted]
Out of Scope	[redacted]

1.4 Health workforce

This item updates you on Out of Scope work to review health workforce regulatory settings.

Out of Scope

Review of health workforce regulatory settings

We are working with Health NZ to develop the end use cases that will illustrate how proposed changes would impact the system. We will send the end use cases to you by mid-June 2024.

Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a)

1.3 Health workforce

This item updates you on Out of Scope the review of health workforce regulatory settings.

Out of Scope

Review of health workforce regulatory settings

We met with the Council of Medical Colleges (CMC) Board on the future of health workforce regulation on 25 June 2024. We discussed the challenges facing the workforce and the opportunity to help improve outcomes through people-centred, right-touch and sustainable regulation. The CMC Board was receptive to the overarching direction and engagement plan and invited Ministry officials to attend a CMC webinar in August for a more detailed discussion.

We will be briefing you with our proposed engagement plan on 3 July 2024. This will include the end use cases you have requested. We are seeking to meet with all responsible authorities on 9 July 2024 to formally start target engagement. We will use the weekly report to keep you updated on the engagement through-out the process.

We are working with your office on key messages and other communications collateral

Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a)

1.3 Health workforce

This item updates you on Out of Scope , the review of health workforce regulatory settings, Out of Scope

Review of health workforce regulatory settings

We are preparing a briefing on our proposed approach to engagement and indicative use cases that provide tangible examples of what regulatory changes could mean for consumers, regulated practitioners, self-regulated practitioners, and rongoā practitioners.

We are planning to meet with all responsible authorities in July 2024 to inform them of the engagement process and provide an overview of the work programme. This will include the regulatory shifts discussed with you, namely:

- an approach to scopes of practice that empower practitioners to deliver services in line with their full competence
- an alternative form of regulation for lower risk services
- an efficient and responsive regulatory structure that reflects an inter-disciplinary approach to health service delivery.

We will update you on the initial response to the proposals in the Weekly Report following that meeting.

The Ministry will provide your office with key messages and other communications collateral, which we will update as required.

Out of Scope

Out of Scope

Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a)

1.3 Health workforce

This item updates you on the review of health workforce regulatory settings Out of Scope [redacted]

Review of health workforce regulatory settings

We have provided you with a briefing on our proposed approach to engagement and indicative use cases that provides tangible examples of what regulatory changes could mean for consumers, regulated practitioners, self-regulated practitioners and rongoā practitioners [H2024044779 refers].

We are meeting with all responsible authorities (RAs) in the week of 15 July 2024 to inform them of the engagement process and provide an overview of the work programme. This will include the regulatory shifts discussed with you, namely:

- an approach to scopes of practice that empower practitioners to deliver services in line with their full competence
- an alternative form of regulation for lower risk services
- an efficient and responsive regulatory structure that reflects an inter-disciplinary approach to health service delivery.

We will update you on the initial response to the proposals in the Weekly Report for the week commencing 22 July 2024, following that meeting.

We have provided your office with key messages and other communications collateral, which we will update as required.

Following this introductory meeting, we will be holding targeted workshops with RAs, professional associations, Māori health organisations, consumer advocacy groups, and colleges to further develop options for achieving the shifts in workforce regulation.

Out of Scope [redacted]

Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a) [redacted]

1.3 Health workforce

This item updates you on the review of health workforce regulatory settings Out of Scope [redacted]

Review of health workforce regulatory settings

We met with responsible authorities on 16 July 2024. All 18 RAs were represented at the meeting.

The purpose of the meeting was to start discussing how regulatory settings can help alleviate challenges faced by the health workforce and to support the delivery of timely and quality care to our communities.

We provided an overview of the Ministry's thinking to-date, introduced some ideas that will be consulted on in the coming months, and talked about the engagement approach that will be used to develop ideas for the future of health workforce regulation.

The meeting provided the opportunity for RAs to immediately feed back on the proposed work and engagement approach. The discussions centred around the broad shifts in workforce regulation that the Ministry is proposing with a range of views across the 18 RAs. The RAs expressed great interest in exploring alternative forms of regulation for low-risk professions and options for improving RA sustainability. The RAs were eager to continue the conversation on these shifts to better understand the opportunities in this work.

The Ministry will be holding workshops with the RAs, and wider health workforce stakeholders, throughout July and August 2024 to further develop proposals.

Out of Scope [redacted]

Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a) [redacted]

10.2 Planned communications

Out of Scope [redacted]

We have provided your office with an update of work taking place as part of the Ministry's review of the current regulatory settings for health workforce. The Ministry is now looking at options to effectively enable our workforce to work to their full potential. This may include changes to the current Health Practitioners Competence Assurance Act 2003 or new legislation.

Out of Scope [redacted]

Deputy Director-General	Sarah Turner, Deputy Director-General, Government and Executive Services – Te Pou Whakatere Kāwanatanga, S9(2)(a) [redacted]

1.3 Health workforce

This item updates you on the review of health workforce regulatory settings Out of Scope

Review of health workforce regulatory settings

The Ministry of Health (the Ministry) will be holding workshops with the responsible authorities (RAs) and wider health workforce stakeholders throughout July and August to further develop proposals.

We have sent invitations to RAs for workshops with Ministry officials on 29 and 31 July 2024 to discuss the specific shifts and develop proposals for public consultation later in the year. In these workshops we will discuss options to:

- improve recognition of practitioner competencies to better enable our workforce to deliver timely and quality health services
- design alternative forms of regulation for lower risk services
- improve the delivery of regulatory functions.

We expect a lot of interest as it will provide more detail on the proposed changes and give them their first chance for feedback.

Out of Scope

Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a)

Future of Health Workforce Regulation

Introduction and overview

July 2024

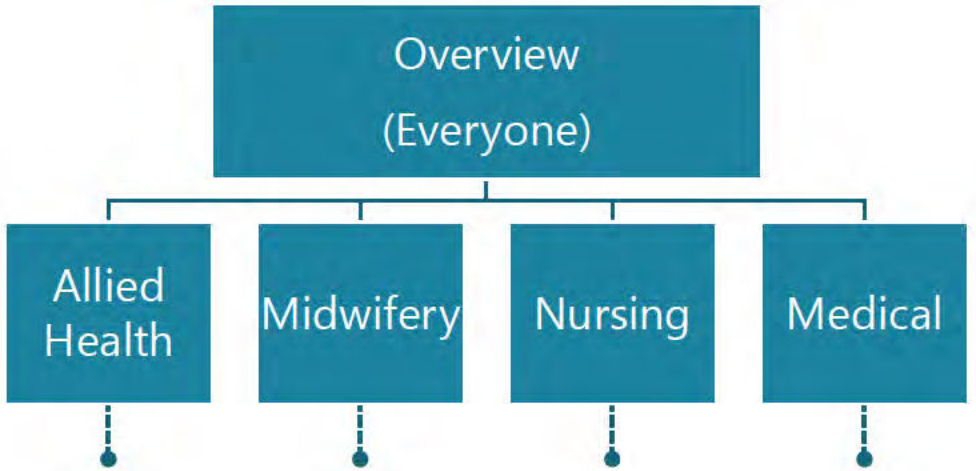
Karakia timatanga

Whakataka te hau ki te uru,
Whakataka te hau ki te tonga.
Kia mākinakina ki uta,
Kia mātaratara ki tai.
E hī ake ana te atakura
He tio, he huka, he hauhu
Tihei Mauri Ora!

The wind swings to the west
Then turns into a southerly.
Making it prickly cold inland,
And piercingly cold on the coast.
May the dawn rise red-tipped
On ice, on snow, on frost.
Join! Gather! Intertwine!

Purpose and structure of today's meeting

- Provide overview of thinking
- Introduce ideas
- Discuss engagement approach



We're at the start of the journey and want to work with you throughout

Setting the future direction of health workforce regulation requires collaborative and constructive engagement across government, sector and community.

Phase 1: Targeted engagement

July-September 2024

- Initial discussions with key stakeholders.
- Develop proposals for public consultation.
- Identify unintended consequences as soon as possible.

Public consultation document

Phase 2: Public consultation

S9(2)(f)(iv)

[redacted]

Policy positions and decisions

Phase 3: Ongoing engagement

S9(2)(f)(iv)

[redacted]

New legislation / implementation

NOT GOVERNMENT POLICY

Workforce regulation is part of a broader programme to improve health outcomes

- Government Policy Statement on Health 2024-27
- Objective 4.3: Retain, value, and recognise the workforce
- Expectation: Review regulatory settings related to the health workforce

The health workforce is facing significant challenges to meet the needs of New Zealanders

- Shortages
- Burnout
- Cultural and disability competence
- Underrepresentation
- Limited capacity and range of services in rural areas

The way we regulate the health workforce is one way to help address these challenges

- Flexible and proportionate regulation that reflects how health services are delivered today
- Break down unnecessary barriers (professional and regulatory)
- Enable shifts in other policy levers

While we are looking for improvements, some things will not change

- Patient safety is paramount
- Decisions are evidence-based
- Professions retain identity and mana
- Regulation should not unnecessarily restrict access or stifle innovation

The future of health workforce regulation seeks to meet three objectives

People-centred regulation

Needs of people and the wider health system at the heart of regulatory decision-making.

Right-touch regulation

Level of regulation proportionate to level of risk to public safety.

Sustainable regulation

Regulatory settings adapt to changing needs and models (inc. financial sustainability).

We are considering three regulatory shifts to meet these objectives

Scopes of practice

Approach to scopes of practice that empowers practitioners to deliver services in line with their full competence.

Models of regulation

Alternative forms of regulation proportionate to level of risk to public safety.

System form and function

Efficient and responsive regulatory structure that reflects an inter-disciplinary approach to health service delivery.

Next steps

- Circulate slides and notes from today's meeting
- Schedule engagements, workshops, etc.
- Updates in existing meetings
- Public consultation later this year

Breakout groups

1.3 Health workforce

This item updates you on the review of health workforce regulatory settings Out of Scope [redacted]

Review of health workforce regulatory settings

Ministry of Health (the Ministry) officials held workshops with responsible authorities (RAs) on the proposed regulatory shifts on 29 and 31 July 2024. There has been a lot of interest in these workshops. All RAs are attending, some with more than one participant.

There was a high level of engagement from the workshop participants, with positive comments on the openness on the outcomes being sought. The feedback was that they appreciated the opportunity to be involved and felt that we were engaging in an open way.

This engagement is on the objectives of the review and the shifts we have identified. There was a lot of positive engagement on where there may be benefits in structural change. We were clear that professional distinctions remain important, and they will be able to help shape proposals.

You will be consulted on the options before any public conversations on them occur

Out of Scope [redacted]

Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a) [redacted]

1.4 Health workforce

This item updates you on the review of health workforce regulatory settings Out of Scope [redacted]

Review of health workforce regulatory settings

Ministry officials are continuing targeted engagement on proposed regulatory shifts.

We have provided responsible authorities (RAs) with a summary of the 29 and 31 July 2024 workshops and arranged follow-up meetings with those who requested them, the Nursing Council, the Medical Council and the Midwifery Council. RAs have expressed that the current timeframes to develop detailed proposals for public consultation may not be sufficient. We are reviewing our consultation and engagement approach to enable you to receive more tangible and refined change proposals to consider and discuss with your Cabinet colleagues by the end of the year. S9(2)(f)(iv) [redacted] We will brief you on proposed engagement process changes in light of this feedback from RAs.

Officials will continue discussions with wider health workforce stakeholders including professional associations, colleges, Māori health organisations, rural health organisations and service providers.

We will update you on these engagements in future Weekly Reports.

Out of Scope [redacted]

RAG Status	
Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a) [redacted]

Document 14

Hauora Taiwhenua Rural Health Network 19 August 2024:

Attendees:

- S9(2)(a), CE
- S9(2)(a), GM Advocacy
- S9(2)(a), Clinical Director Rural Health
- Jay Andrew
- Eddy Sommers
- Ben Clayton

Meeting notes:

General statements

- Ministry of Health gave an overview of journey to date.
- Hauora Taiwhenua attendees generally supportive of the direction of change.

Scopes of practice and recognition of skills

- Support in principle recognising practitioner skills and development, e.g. micro-credentialling. Seeing a shift to generalism in rural settings and proposals support this.
- Need to ensure it doesn't introduce more (or increase existing) barriers and rigidity, e.g. limitations on nurses taking blood despite competence to do so.
- Need to consider transferability of recognition of a practitioner's competence if changing employer.
- Proposals have implications for supervision. Traditionally doctors have taken on this role however who will be responsible for the increase in supervision that these changes demand?
- Public still has an expectation that they will see a doctor. Will need to change culture/public expectations alongside changes to legislation. Gave example of Taupō and the move to a generalist workforce.
- Gave example of extended care paramedics working in primary care – questioned whether the public would view this differently to a triage nurse or GP.

Centralisation and decentralisation of functions/decision-making

- Gains to be had from centralisation and a consistent approach to workforce issues (e.g. if a practitioner's records are centralised, different employers/commissioners have access to the same information). However, need to be mindful of unfavourable public perception of centralisation and be able to demonstrate tangible benefits.
- Role of employer in identifying skills of practitioner:
    - Good idea in principle so long as the employer has the knowledge/skills to understand practitioner's scope of practice, what competency is required, and what scope should deliver. Contingent on knowledge and understanding of employer (typically an organisation).
    - Responsibility for skill recognition could be delegated (e.g. to knowledgeable employer). This would help to alleviate the burden on the regulator.
    - Mindful of potential for employers to have a conflict of interest – there needs to be checks and balances within the system.
- Colleagues often have a good understanding of each other's scopes of practice and can hold one another to account. Potentially a role for practitioners (collegial critique) in this space.

Rural health

- Rural and urban scopes of practice are different. There isn't always access to specialists in rural settings. Gave Australian example of rural generalism scope of practice – this is more about safe clinical decision-making than specific tasks.
- The only rural generalist practitioners in New Zealand are working on the West Coast and are operating under the Australian model.
- Medical Council has been restrictive in registering IMGs on the basis of practitioner competency. This is an example of a barrier that affects patient safety through limited access. Need to take a broader approach to patient safety when making regulatory decisions.

Next steps

- Ministry of Health to develop and share more detailed, tangible proposals, considering feedback during targeted engagement.
- Hauora Taiwhenua to consider engaging networks to seek views on more detailed proposals, once proposals are in a state to be shared.

Document 15

Professional associations 20 August 2024: Health Workforce Regulation

Attendees:

Martin Chadwick	S9(2)(a) Pharmaceutical Society
Lorraine Hetaraka	S9(2)(a) College of Midwives
Heather Muriwai	S9(2)(a), Dental Association
Riana Clarke	S9(2)(a), Association of Counsellors
Steve Osborne	S9(2)(a), Association of Counsellors
Suzanne Townsend	S9(2)(a), Pharmacy Guild
Jay Andrew	S9(2)(a), College of Nurses
Eddy Sommers	
Ben Clayton	

Meeting notes:

<u>General comments</u>

- Unclear the extent to which regulation will be able to fix the problems facing the health workforce.
- Many current issues may be related more to how the Act is interpreted/implemented, as opposed to the regulatory settings not being enabling.
- Workforce planning is a pressing issue – need to consider how workforce regulation intersects with workforce planning.
- Important that the regulator is independent from the Ministry. There is also a need for laypeople to be represented.
- Concern regarding the HPCA Act's commitment to Te Tiriti.
- Streamlining regulatory processes for overseas health practitioners wanting to work in New Zealand is one way regulation could help address workforce challenges.
- Regarding COVID-19 example used in background materials, need to be mindful that this was an emergency scenario, and there is a need to follow proper processes when developing proposals.
- There is an opportunity for the way APC fees are set to be streamlined/made more efficient and effective.
- Some practitioners work in education settings. How would proposals work in relation to these practitioners?

<u>Scopes of practice and skill recognition</u>

- While there is a place for micro-credentialling, there is also danger in a practitioner having a multiplicity of small credentials that aren't necessarily transferable or enable professional development. There is a need for some kind of interface that recognises such credentials.
- The proposed approach to scopes of practice is very different from the current approach of generalised, broad scopes. It would be very difficult and inefficient to list all the tasks a practitioner undertakes.
- Employer credentialling wouldn't work for the self-employed workforce.
- Suggested development of a pan-professional scope of practice.

- Rural generalism model for rural hospital doctors is a good example of the current regulatory model working well.

Intermediate tier of regulation

- With respect to pharmacy technicians, there is already a clinical governance framework (role of a registered pharmacist to provide oversight in pharmacy setting). A second tier of regulation, therefore, may not be necessary/appropriate.
- Title protection currently an issue for self-regulating professions, e.g. counsellors. Some people are causing harm to consumers. Association is trying to promote registered counsellors to consumers – provides some assurance of safety and quality.

Document 16

Minutes

Allied Health Responsible Authorities Group

Date:	20 August 2024
Time:	1.00 pm – 1.50 pm
Location:	Microsoft Teams
Chair:	Martin Chadwick
Attendees:	S9(2)(a) [redacted] Jacqui Lunday Johnstone, S9(2)(a) [redacted] Steve Osborne, S9(2)(a) [redacted] Caitlin Yeoman (minutes)
Apologies:	S9(2)(a) [redacted], Lauren Hancock, S9(2)(a) [redacted]
Guest:	Jay Andrew

Item	Notes
Out of Scope	[redacted]
3	Reflection on regulatory review process to date • If you have any questions since the workshops Jay is happy to answer those either now or come back with an answer. • Draft notes from the workshops have been circulated, if there is anything that has been missed or any issues, please let Jay know so he can amend the notes. • Feedback received from the workshops that it may be worthwhile to extend the consultation process before public consultation. • The team are considering whether scopes the right way to empower the workforce to deliver everything they need to or are there other/additional mechanisms. There is also an ongoing thought process regarding the intermediate tier of regulation for lower risk services.

Questions?

- When do you think you will be able to update us on the timeline if there are changes?
  - Jay's team need to seek agreement from Minister Reti before they can confirm. The intent of the updated plan is to not impact the longer-term timelines, but more a reordering of elements in the next 6-12 months – S9(2)(f)(iv) [redacted] Should be able to give an update in the coming weeks.
- There was a group discussion at the workshop regarding seeking evidence around risks – will that come out during consultation or prior?
  - This was regarding what Jay was referring to around whether scopes are the right mechanism. If they can find that data – if it exists – they will continue to develop the evidence base. If they have the data, it will be shared.
- The RAs all have a wealth of data and information, what else can they do to help?
  - Jay will think about that and reach out if he needs anything.
- Is there potential that the date the Bill is introduced may be affected by the possible changes?
  - Yes, there's always a possibility. The team will do everything they can to meet that but prefer to have a good product and good outcomes and do the right thing rather than forge ahead with the dates.
  - There are some things that are harder to change (e.g., legislative timetable), there would have to be very good reasons to shift.
- Potential effects on timelines for reporting?
  - S9(2)(f)(iv) [redacted]
- Some RAs have already progressed through scope of practice reviews. Should these continue or should we wait to see what happens, given how expensive and time-consuming these things are?
  - We must enact the current legislation. You must continue to discharge those functions. There may come a time when there is a go/no-go – continue as normal until then.

Out of Scope [redacted]

Document 16

Out of Scope

[redacted]

Out of Scope

[redacted]

1.4 Health workforce

This item updates you on the review of health workforce regulatory settings, Out of Scope [redacted]

Review of health workforce regulatory settings

This week Ministry officials met with Hauora Taiwhenua, professional associations, and had a follow-up meeting with the Nursing Council. The conversations continue to be constructive and useful. There is growing agreement that the regulators need to be more system focussed and consider government priorities. The discussion on joint decision making and second tier regulation is ongoing.

The next meetings will be with primary health organisations (PHOs), Health NZ, and the Council of Medical Colleges (CMC).

We will be providing you with advice on the range of choices you have for regulatory change next week following engagement with the HWSEC.

Out of Scope [redacted]

RAG status:	**19 August 2024:**  **12 August 2024:** 
Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a) [redacted]

1.4 Health workforce

This item updates you on the health workforce regulatory settings review Out of Scope [redacted]

Review of health workforce regulatory settings

During the week beginning 26 August 2024, Ministry officials met with Health New Zealand's commissioning team, Tū Ora Primary Health Organisation (PHO) and the Council of Medical Colleges.

These discussions have been constructive and are informing the development of options to improve regulatory settings. There is consistent agreement from stakeholders that the regulatory structure could be streamlined to be more efficient, focused on the health system and collaborative.

The next engagements will include Māori health professional organisations and a meeting on ensuring safety with the Health Practitioners Disciplinary Tribunal, the Health and Disability Commissioner, and the Health Quality and Safety Commission.

Out of Scope [redacted]

RAG status:	26 August 2024:  19 August 2024: 
Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a) [redacted]

1.4 Health workforce

This item updates you on the review of health workforce regulatory settings Out of Scope [redacted]

Review of health workforce regulatory settings

Ministry officials attended a meeting with the Council of Medical Colleges (CMC) to discuss the future of health workforce regulation. CMC members welcomed the opportunity to hear about the work programme and ask questions. They were particularly interested in approaches to skill development and recognition, including the role of micro-credentialling in a future regulatory system, and the practicalities of a more flexible approach to competency recognition. The CMC offered to provide further support in the development of proposals.

Out of Scope [redacted]

RAG status:	5 September 2024		29 August 2024	
Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a) [redacted]			

Document 20

Minutes

Self-regulating professions hui

Date:	10 September 2024
Time:	1.00 pm – 2.20 pm
Location:	Microsoft Teams
Chair:	Lauren Hancock
Attendees:	S9(2)(a) Jacqui Lunday, S9(2)(a) Caitlin Yeoman (minutes)
Apologies:	S9(2)(a)
Guest:	Jay Andrew

Item	Notes
S9(2)(a)	
	• HPCA Act review: it's time for self-regulating professions to have input into the regulatory framework. We haven't determined yet which option is best, hence going through the consultation process.
Out of Scope	

Out of Scope [redacted]

4	Review of the HPCA • The policy team has had consultation meetings with many professions including the regulated allied health professions. They have more meetings booked, including with Māori practices and Rongoā practitioners. • Three primary principles of the regulatory review: o People-centred regulations: currently regulation focuses more on the professions than on patients. o Reflecting diversity of health services in regulation: comparing levels of risk to levels of safety. Currently regulation is binary – either you are regulated, or you are not. This is not effective. o An adaptable regulatory system that is financially sustainable. • Current system is restricting professions from fulfilling their scope of practice – need to enable flexibility to fulfil community needs. Agreement in principle to deliver services to complete scope, but feedback was that scopes of practice aren't the appropriate lever to do this. • Establishing an intermediate tier of regulation – not as restrictive as HPCA Act but recognising the work that you all have done. • Looking at a similar system to the UK to have accredited professions. A review by the WHO of international health practitioner regulation systems is attached to these minutes. • Looking at the roles of various participants (regulators, the Ministry, the Minister). Need to ensure that form follows function, e.g., is there still a need for 18 separate regulators – some already share services. • How is level of risk assessed for professions? o A risk matrix is used as part of the decision process for regulation applications. • Very cautious to refer to "lower risk" as there is no such thing as low risk. Shift thinking away from "regulation is recognition" to thinking about the level of risk. • The new system needs to be workable and financially sustainable. Fees will be a potential barrier for many. Smaller groups could choose to come together to reduce costs. • Title protection is another recurring issue. What could be incorporated into the future system for self-regulated professions and currently regulated professions to choose to be regulated at an intermediate level? o If a currently regulated profession is determined to be suitable for an intermediate level, that decision may be left to the profession – we will need to wait for criteria to confirm the process. o Self-regulated professions may also be encouraged or invited to apply, but again, none of this has been decided. • Stakeholder engagement is happening now with formal consultation over the next 6-8 months. S9(2)(f)(iv) [redacted] There is always the option to do nothing – stick with status quo. This is part of engaging with you and we are keen to hear your thoughts so we can include more detail. • The type of regulation can be restrictive or enabling. From NMHNZ (Naturopath and Medical Herbalists of NZ) perspective they would like it to be enabling. Naturopathy is in UK is where it was in NZ in the 90s – not the

same as where it is now. The risk association now is on par with traditional Chinese medicine. Regulation is a carrot if title protection is policed, so that only those suitably qualified can use the title. What other carrots are there that would be meaningful?
    - Jay agreed that that's a great point, what could those other carrots be? The policy team is open to that discussion.
    - For herbal medicine and naturopathy that could be access to scheduled herbs. There also needs to be research funding for complementary medicine.
- Changing culture – instead of talking about "second tier" or "self-regulation" it should just be regulation.
    - Jay agrees that we need to find language that is positive but gives distinction to levels of regulation.
- Other regulatory/safety needs:
    - Needs to enable access to services as part of patient safety.
    - Support contemporary ways of working – multidisciplinary work, extensions of scope or working to fullness of scope.
    - Right touch regulation.

Positives of self-regulation

- Self-regulation is cheaper than under the HPCA Act.
- Practice standards and complaints processes can be tailored more effectively to the profession. This is why DAPAANZ didn't apply to be under the HPCA ACT. They have situations that are unique to their profession and so their complaints process needs to match that.

Issues with self-regulation as it is

- There is a lot of time spent explaining why an organisation is self-regulated. Regulation is not mandatory and it should be. Inability to grow and be innovative because you're stifled by your funds.
- How big is too big? Addiction practitioners can't get enough practitioners, but concern about how they can grow their regulator as they grow their workforce.
- Exercise physiologists have issues because they do not have proof of industry demand. Regulation would give them recognition to be able to leverage more university qualifications.
- The interface with training and education is difficult. More training and more qualifications are needed for addiction practitioners.
- As far as complementary medicine goes, they need to go to Australian universities to discuss education needs. No interest from New Zealand educators.
- A lot of commercial elements to Audiology that impact on the profession too and make it a bit more complex. There is funding for services that are within their scope but stuck behind the HPCA Act.
- Music therapy is limited in New Zealand to only a few avenues – regulation could mean that GPs could refer to music therapy. Don't want to be restricted to private patients only (i.e., those who can afford treatment).
- Hypnotherapists have similar access issues with GPs unable to refer directly. Accessibility and affordability is an issue for patients – not ACC funded. There is also limited consequence for practitioners involved in the complaints process.
    - Jay cannot guarantee that this process will enable ACC funding – ACC are included in this consultation, but they make their own decisions.

	• The lack of recognition with self-regulating professions in legislation. Ministers, ACC, Te Whatu Ora and Manatū Hauora are looking at risk through a legislative lens. o ACC are also looking at outcomes. • Acknowledge that regulation works really well for some groups but doesn't work at all for other groups. This is particular to regulation but there are many connections. There is the opportunity to have a look at the documents attached to the agenda today – conversation needs to remain in scope (i.e., need to look at what we can change at this time). It doesn't happen in isolation – ACC is a key part, but they don't do regulation. Looking at what we can do with this piece of work. • The intention is to recognise what already exists – will look at different models. • From naturopaths and medical herbalists – don't have an issue sharing a register and complaints process, but don't want to come under an umbrella organisation that negates the process that they have made with education levels and research, setting clinical standards etc. • An example of self-regulation overseas: https://nasrhp.org.au/ • Please send any feedback to Jay at jay.andrew@health.govt.nz by COP Friday 20 September. Jay is also happy to meet with your organisation if you would like.

Out of Scope [redacted]

Item	Action	Lead	Due Date
4	Send feedback to Jay on the regulatory review	All	20/09/2024

1.4 Health workforce

This item updates you on the review of health workforce regulatory settings. Out of Scope

Out of Scope

Review of health workforce regulatory settings

We have briefed you on the range of options for changing workforce regulation.

We are continuing our targeted engagement. We intend briefing you on engagement outcomes in early October.

Out of Scope

RAG status:	12 September 2024		5 September 2024	
Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a)			

1.4 Health workforce

This item updates you on the review of health workforce regulatory settings, Out of Scope [redacted]

Out of Scope [redacted]

Review of health workforce regulatory settings

Ministry officials are drafting a work plan to expedite the workforce regulation programme S9(2)(f)(iv) [redacted]. Meeting this deadline will require Cabinet agreement to policy positions ahead of Christmas, meaning that public consultation will be conducted through the select committee process.

The Ministry continues to hold targeted engagement with key stakeholders. This week the Ministry held a meeting with Māori practitioners and has scheduled meetings with unions. We have been in contact with Te Kāhui Rongoā to arrange a meeting to discuss opportunities for rongoā practitioners.

Out of Scope

RAG status:	19 September 2024		12 September 2024	
Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a)			

Document 23

From: Caitlin Yeoman
Sent: Monday, 23 September 2024 11:25 am
To: Admin NZAPH; Jay Andrew
Subject: RE: Feedback on Proposed Changes to Health Workforce Regulation – NZAPH's Perspective

Kia ora Meredith

Out of Scope .

@Jay, please see below feedback from the New Zealand Association of Professional Hypnotherapists.

Ngā manaakitanga

Caitlin

From: Admin NZAPH <info@nzaph.com>
Sent: Friday, September 20, 2024 11:37 AM
To: Caitlin Yeoman <Caitlin.Yeoman@health.govt.nz>
Subject: Feedback on Proposed Changes to Health Workforce Regulation – NZAPH's Perspective

Kia ora,

On behalf of the New Zealand Association of Professional Hypnotherapists (NZAPH), I would like to offer feedback regarding the proposed regulatory changes outlined in the *Future of Health Workforce Regulation* discussion document. We appreciate the Ministry's efforts in shaping a health workforce regulation framework that prioritises people and ensures sustainability for all health professions in Aotearoa.

As a smaller professional organisation representing hypnotherapists across the country, we've carefully considered how these changes may impact our members. Below are the key areas we'd like to highlight to ensure that our unique needs are addressed:

1. Proportional Regulation

We support the development of a regulatory framework that reflects the risk profiles of different professions. Hypnotherapy is a low-risk service, and we advocate for inclusion in an **Accredited Register system**. This would provide a balanced level of oversight, ensuring quality and safety without imposing an unnecessary regulatory burden.

2. Financial Sustainability

Like many small organisations, NZAPH faces financial challenges under the current "one-size-fits-all" model for registration fees. We request that the framework includes **flexible fee structures** that account for the size and revenue of smaller professions, ensuring that hypnotherapy remains accessible and sustainable across the country.

3. Recognition of Full Competence

Many hypnotherapists develop additional skills that go beyond traditional therapeutic roles. We strongly support a framework that recognises the **full scope of practitioners' competencies**, allowing them to play a meaningful role in interdisciplinary teams, particularly in mental health and pain management.

4. Cultural Safety

NZAPH is committed to providing culturally safe services, particularly for Māori and other underserved groups. We appreciate the focus on cultural safety in the proposed framework and would welcome **clear guidelines and resources** to help us integrate cultural competence into our training and certification processes.

5. Interdisciplinary Collaboration

Hypnotherapy has a vital role to play in **team-based care**. The regulatory framework should support collaboration between hypnotherapists and other health professionals, allowing us to contribute to solutions for workforce shortages, particularly in rural and underserved areas.

6. Simplified Registration Processes

A streamlined and simplified approach to **registration and certification**, especially for internationally trained practitioners, would reduce the administrative burden for smaller professions like hypnotherapy. This would allow us to respond more efficiently to workforce demands while maintaining high standards.

We appreciate the Ministry's efforts in considering the needs of all health professions and look forward to continuing our collaborative efforts to shape a regulatory framework that is both flexible and fair for smaller professions like ours. We would be happy to discuss our feedback further and contribute to any ongoing consultations.

Ngā mihi nui,
Meredith McCarthy
President, New Zealand Association of Professional Hypnotherapists (NZAPH)
S9(2)(a)

1.4 Health workforce

This item updates you on the review of health workforce regulatory settings, Out of Scope [redacted]

Review of health workforce regulatory settings

We have provided your office advice on options and risks for expediting the health workforce regulation review on 27 September 2024.

Out of Scope [redacted]

RAG status:	26 September 2024		19 September 2024	
Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a) [redacted]			

Date	**2 October 2024**
To	**Suzanne Townsend, Manager Regulatory Policy, Ministry of Health** **Jay Andrew, Principal Policy Analyst, Ministry of Health**
From	**Collective of Health Responsible Authorities**
Topic	**The Future of Health Workforce Regulation Responsible Authority workshops conversation summary sheet**
Purpose	**Provision of feedback from 9 Health Responsible Authorities: Chinese Medicine Council of New Zealand, Dietitians Board, Medical Sciences Secretariat Limited, New Zealand Psychologists Board, Occupational Therapy Board of New Zealand, Optometrists and Dispensing Opticians Board, Paramedic Council, Physiotherapy Board, Podiatrists Board**

Re: The Future of Health Workforce Regulation

Thank you for the opportunity to provide feedback following the Future of Health Workforce Regulation workshops held on 29 and 31 July 2024. Following both workshops, responsible authorities (RAs) were provided with a summary noting table on 16 August seeking any corrections and/or additions to be made to the record of conversation.

Collective feedback on the workshop summary notes is presented from nine of the eighteen health responsible authorities. We believe that, for an effective policy outcome, ongoing and transparent consultation is essential. We look forward to further engagement with the Ministry of Health.

Overarching feedback

Overall, the conversation points were captured. However, there was a level of misrepresentation as well as some omissions. Initially, it seemed as if the workshops were constructed to lead the participants, and it was well into the sessions that the attendees felt the Ministry staff were genuinely seeking constructive conversation.

The rationale for policy change and problem definition shifted during the sessions and lacked robust clarity. There are some key components for this policy work that were not discussed at the workshops. As these are critical to legislative change and regulatory function, at some point, we will need to bring these to the attention of the Ministry and discuss them.

The workshops would have benefited from discussion on the Government Policy Statement on Health and linkage with proposed regulatory change. The Health Quality and Safety Commission (HQSC) will shortly release the paper "Collaborating for Quality - A Framework for Clinical Governance". Clinical Governance is a strong lever to effecting safe clinical

practice and diminishing risk at the frontline. The HQSC may provide more substantial solutions to risks to patients than those proposed by the Ministry at the workshops. Given the current state of frontline health, instability and change fatigue within the sector, we caution creating significant change in what is a well working health regulatory environment.

We understand the Ministry's need to better manage unregulated and self-regulating work force groups that are not included in the Health Practitioners Competence Assurance Act 2003 (HPCAA). If there is immediate risk to public safety with unregulated and self-regulated professions, then the Ministry would likely wish to focus policy on setting up a system whereby this specific cohort might be monitored.

The RAs are genuinely keen to be involved with shaping changes to the HPCA Act. We have a wealth of knowledge and regulatory experience as to what could be retained, amended, or included in any new legislation. We seek to collectively work with, and to present to, the Ministry changes that we believe are necessary for sustainable and effective health workforce regulation.

We welcome an opportunity to discuss accountability to the Minister of Health and our upcoming shared work programme. The programme currently includes standards (prescribing), position statements (interprofessional collaboration in practice), and national frameworks (cultural safety).

Opening Comments

- A statement was made that "The RAs are doing exactly what the HPCA Act requires, no one is suggesting they are not." Please include this in the summary.
- Indication was given that Te Tiriti would be respected and included as part of the discussion at a later date. It is important that this is acknowledged in the summary.
- Statement made that the Ministry is open to new ways of solving the issues. Please include this in the summary.
- Overstated is the place of regulation in resolving systems issues related to patient harm.
- Concerns were raised about the quality of information and policy analysis pre-workshop that informed the workshop, a lack of problem clarity, guiding of the agenda to influence rather than create open listening and learning, consultation timeline and timeframe of review.

Theme Feedback

Theme One: Approach to scopes of practice that empowers practitioners

Incorrect or was not in the conversation/discussion but appears in the summary:

- 'Tiers' of regulation feature predominantly in the summary, however, this was not the case in discussions at the workshops.
- *"An intermediate tier of regulation would be good for professions with less risk and a small number of practitioners."* - Misrepresented as conversation included that Tiers will only work

if the public/consumers understand them. As it is, there is a tiered system (those regulated by the HPCA Act, those self-regulated and those un-regulated) and the public/consumers struggle to understand how the system works. Without improving health literacy there is no point creating a different tiered system.

- *The HPCA Act is a very enabling piece of legislation.* Please delete following sentence - *If a scope of practice is overly restrictive, this is because of the regulator's interpretation or willingness, not the legislation itself. Group 2*

Missing and it was in the conversation/ discussion:

- *Standardisation of scopes of practice (e.g. language and format) to improve consumer understanding. Group 2* At the workshop this was clarified to be the standardisation of wording used in describing scopes, as opposed to the scopes themselves. Please make this clear in the summary.
- Workforce consists of employed and self-employed, and this was discussed at the workshops. There is a lot of discussion that employers' impact on the scope but there are several professions that are largely self- employed.
- HPCAA 2003 S22 already allows practitioners to work to their full scope, why does the Ministry think change to legislation is needed for this?
- How do we enable all the professions to work across the workforce on an equal footing?
- Relying on credentialling (if it's working well) for broad scopes is fine for some workforces, but this doesn't capture the self-employed workforce. Public understanding of who they can go to for care, and public funding for it, drives a lot of peoples' health choices and decisions. Finding a solution for this issue should seek to empower all practitioners, not just the core health professions.
- Concerns re. employers making decisions to do with scopes of practice Group 2 *Employers don't necessarily understand scopes of practice. Position descriptions will sometimes specify things that are outside a practitioner's scope of practice*. Missing: The power imbalance means practitioners are unlikely to dispute position descriptions that can lead them to practice outside their scope.
- *Broad scopes of practice require good credentialling at the employer level (noting, however, that currently not all employers conduct credentialling). Group 1.* Missing is the concern raised about vested interest of employers in credentialling.
- *Practitioner scope decisions are best made between employee and employer):* There was some concern raised about this.
- *Employers don't always understand a practitioner's scope of practice. This can limit what functions they will allow a practitioner to perform. Similarly, employers may ask a practitioner to do something outside their scope of practice. Group 1*. It was stated that the practitioner has a responsibility to know their own scope of practice.

Additional points that need to be considered:

Patient risk as a problem wasn't heavily outlined at the workshops. However, this was presented as the platform for the proposed RA changes. The bulk of the time in the workshops was spent on the proposed solutions that the Ministry's regulations team have landed on. Within the workshops there was a lost opportunity for genuine discussion on how the regulatory system is currently effecting improvements in consumer safety and barriers that we require policy support with, including key changes to the HPCA Act.

The expanded use of clinical governance as the system to govern inter-disciplinary safety, has more nimbleness to respond to the problem than RA settings. Not discussed at the workshops is that the HQSC as part of its area of expertise, has been working on the issue of system wide safety improvement for quite some time. The HQSC has a much broader perspective on things, and on the suite of solutions. The HQSC's paper, 'Collaborating for Quality -A Framework for Clinical Governance', which is due to be finalised shortly, may provide more substantial solutions to risks to patients than what was proposed at the workshops.

- *Recognition of the need to strengthen the relationship between RAs and the HDC.* Missing was timeliness of the HDC's process. It is important to look at which matters are best promptly referred by HDC to the RA so that the RA, who has the power to take steps to protect public safety, can intervene in a timelier manner than is currently possible.
- There was a lack of clarity at the workshop on how challenges within the disciplinary process were to be addressed, the relationship with the HDC strengthened, and what effect these things would have on addressing workforce shortages etc. or increasing accessibility to services for patients, or facilitating practice across scopes/alignment of scopes etc.
- It is more likely that public education and looking at educational institutions would have more of an impact. RAs' impact relates to accreditation of programmes for the purposes of registration.
- *Education of the public is vital in promoting interdisciplinary models of care. The public needs to be assured that it's okay to see different types of health practitioners. Group 2,* but this only goes so far if funding doesn't follow the patient. While patients can be educated regarding the different types of practitioners they could see for a particular condition, this won't really help if the practitioner they would choose to see isn't funded to provide the service they need.
- *Education institutions have a role in teaching practitioners about cross-profession service delivery → accreditation standards. Group 2.* Note educational institutions that want their programmes accredited by the relevant RA would also consider the RA's accreditation requirements in formulating their programmes/courses.
- *Scopes of practice are not the only barrier - even if a scope is broad/enabling, there are other barriers stopping practitioners from working at top of competence (e.g. IMAC in the case of vaccinating). Group 2.* What is the Ministry's role in addressing "patch protection" amongst those in professions that seek to bar those from other professions who have the education and training to safely undertake the same activities? It shouldn't be up to the RAs to do this (or to the RAs alone).

Theme Two: Alternative form of regulation

Incorrect or was not in the conversation/discussion but appears in the summary:

> *'An intermediate tier of regulation would be good for professions with less risk and a small number of practitioners'.* Most importantly, this was mentioned in the context of discussions about <u>currently unregulated professions</u> **not** currently regulated professions.
>
> - The sentence needs to be changed to more accurately describe the context. Firstly, "may" should replace "would" and "self-regulating / unregulated" needs to be inserted.

- ''Professions with less risk and small numbers of practitioners' is not actually defined anywhere, so the statement is subject to a great deal of interpretation.

Missing and it was in the conversation/ discussion:

- What the public understand about their providers and how they are accountable/the current system is important. There is no point making change if it doesn't lead to greater health literacy. Greater health literacy for the public is paramount.
- Is it better for everyone to be 'in the boat' for safety and inclusivity, and to encourage people into the workforce of these professions?
- An extension of section 7 of the HPCA Act to other professions could be considered, to deter those working outside the lines.
- *What can we learn from the UK's accredited register experience?* Missed: what can be learned from UK's experience and what is relevant to the NZ environment?

Discussion on the meaning of risk: Group 2

- There are two parts to risk: (1) clinical competence and (2) practitioner conduct/behaviour.
- *Risk emerges from the interactions between a practitioner and other elements of the system (e.g. employer expectations, physical environment, actions taken by colleagues, etc.).* Missing: As these elements are not in the regulatory remit, feedback was given that regulation isn't an efficient format to address where these areas of risk lie.
- *Question whether an intermediate tier would proliferate the number of regulatory bodies and make more bureaucracy. Group 2* Missing: There was not a clear description on the level of risk that an intermediate tier is expected to manage/address. No data could be provided to outline this, when requested.

Additional that needs to be considered:

- The RAs don't have the remit to fix issues in the workplace. There is also difficulty in comparing jurisdictions. The sense in the summary is that the current system is a problem but without any evidence (apart from what the Ministry have heard) and the summary needs to acknowledge that a lot of what is being proposed already happens in some way (this was discussed) and that it works well.
- The pro-active approach of several RAs in the current model may render them "low risk" - that preventative and proactive aspect of the RA role is hard to measure, unless looking at pro-active processes and procedures in place.
- Risk profiles change over time. There isn't a robust correlation between the number of practitioners and the risk profile of a profession.
- *An intermediate tier of regulation could be used as a 'stepping stone' for certain professions – opportunity to move in and out of a profession (e.g. for students who don't finish their training but have certain competencies).* If someone hadn't finished their training, how would their competence be measured? Would there be a minimum level of training that would have to take place first? How would risk be determined here? How would this fit with obligations of RAs to prescribe qualifications/scopes of practice?
- *Mental health is an area that might benefit from an intermediate tier of regulation – there are a number of different professions working in this area, and consumer understanding of the differences between these professions is poor*. Vulnerable consumers and what is evidenced about the risk profile of those professions.

- *Could also consider if any professions currently regulated under the HPCA Act might be better suited to regulation via an intermediate mechanism.* If these professions appear to have a certain risk profile now, how can it be determined that this isn't because regulation is working. If the regulatory requirements changed, what impact on the risk profile? Treasury statements on risk formed part of the process of Ministerial advice in establishing the current RAs.
- *What is the definition of "safety" being used?*
- *Could also consider negative licensing*. No information or discussion about how it would work.

Theme Three: Responsive and efficient regulatory structure

Incorrect or was not in the conversation/discussion but appears in the summary:

Missing and it was in the conversation/ discussion:

- *MoH acknowledged its initial preferred structure was a crown entity to regulate the health workforce, but has taken a step back to consider alternative structures that would deliver on the outcomes it is seeking (Group 2)*
  Missing: Suggestions were made to look across the landscape of the health system and the environments that Multi-Disciplinary Teams operate in and identify where the levers for improvement already exist but are not yet leveraged. Specifically, that clinical governance frameworks could be explored as a place to lift the effectiveness and performance of multi-profession teams.

Additional that needs to be considered:

- *MoH noted that change is required, including the need for greater (but proportional) accountability built into the legislation and opportunities for alignment across professions.* Accountability of whom or to whom is not stated/defined.
- *MoH noted that all options are on the table.* Is this the case?
- *MoH acknowledged its initial preferred structure was a crown entity to regulate the health workforce but has taken a step back to consider alternative structures that would deliver on the outcomes it is seeking (Group 2)* This is inconsistent with a statement that all options are on the table.

Closing Comments & next Steps in summary table

MoH is considering its proposed engagement approach, including the timeline to release a public consultation document later this year, in light of feedback from RAs. This doesn't fit with conversation during the most recent AHRAG meeting (post the workshops) where it was stated by the Ministry that the timeline for implementation was pretty much set in stone

MoH will be engaging with other key stakeholders in the development of the consultation document. The Ministry has also stated that there had already been some discussions with stakeholders prior to talking with the RAs.

1.4 Health workforce

This item updates you on work relating to the health workforce.

Review of health workforce regulatory settings

We have provided advice to your office on options and risks for expediting the health workforce regulation review.

Ministry officials met with the NZ Nurses Organisation (NZNO) on Wednesday 2 October to discuss the review. We are meeting with other unions (ASMS, MERAS, NZRDA, APEX, STONZ and PSA) on 8 October 2024. These meetings provide the unions with an overview of the work programme and an opportunity for them to advise us on any changes they would like to see in the regulatory system. We will update you on these meetings in a future Weekly Report.

Out of Scope

[redacted]

RAG status:	3 October 2024		26 September 2024	
Deputy Director-General	Maree Roberts, Deputy Director-General, Strategy, Policy and Legislation – Te Pou Rautaki, S9(2)(a)			

‘Future of Health Workforce Regulation’ discussion document

New Zealand Association of Medical Herbalists

Background:

The long-standing and membership-approved position of the New Zealand Association of Medical Herbalists (NZAMH) is to pursue regulation of the profession of Western herbal medicine (WHM) under the HPCA Act 2003. The profession was initially accepted for regulation under the Act in 2007, but a series of regulatory reforms and delays have since thwarted progression.

The reason for our steadfast position is that under the current regulatory framework the HPCA Act is the only avenue that can effectively fulfil the following objectives, underscoring its importance to our profession:

1) Protection and clarity of professional title so that patients can be assured of the safety and efficacy of treatment delivered by practitioners holding the title of Western Medical Herbalist.
2) Protection for members of the public who seek WHM treatment by ensuring that registered WHM practitioners meet minimum standards and competencies and provide safe treatment.
3) Acknowledgement of practitioners of WHM as ‘Health Practitioners’ within legislation.
4) Official recognition in the New Zealand public health system to facilitate referrals and ensure that our profession is integrated into the broader healthcare system. Our profession is committed to a multidisciplinary approach to patient-centered, efficient healthcare. We firmly believe that having a seat at the table in this context is crucial for ensuring that our unique perspective and expertise contribute significantly to patient-centered healthcare.
5) Ability to fulfil the full scope of practice of the profession and having a pathway available for being approved for restricted activities such as the use of practitioner-only herbs and parenteral applications.

We consider an additional avenue for health workforce regulation proportionate to risk to public safety, such as an Accredited Register, could be suitable, provided our key objectives can be met as stated above.

Feedback on the propositions in the discussion document:

We note that the propositions in the ‘Future of Health Workforce Regulation’ document are underpinned by the Government Policy Statement on Health 2024-2027, which sets out five priority areas for the New Zealand health system: access, timeliness, quality, workforce, and infrastructure. We welcome the renewed focus on a health workforce that is available, accessible, and responsive to the range and complexity of health needs. We also welcome the renewed focus on prevention, wellbeing, mental health, and lifestyle support. Allied health professions, including WHM, are ideally placed to provide services to fulfil these objectives.

- We support **Objective 1**, which aims to refocus on patient needs and safety, including cultural safety, and acknowledges that patients are at risk if health services are unavailable or inaccessible. We consider the under-regulation of allied health professions, including WHM, and their resulting lack of visibility and availability in the public health system, contributes significantly to this risk. Patients are unable to equitably access our health services and as our title is not protected, those who can afford private services find it difficult to ascertain who is a competent and safe practitioner.
- Without regulation, WHM practitioners cannot work to their full capabilities, accorded by education, training, and experience. For example, WHM practitioners currently have the same access to medicinal herbs as the general public, resulting in an inability to practice to the full scope of our profession. Therefore, we support the proposition that each profession's scope of practice should clearly set out the standard services a practitioner of that profession is competent to provide.
- We also consider that an individual practitioner's scope of practice should be flexible enough to be extended subsequent to post-graduate upskilling to deliver further services such as primary care tasks to reduce pressure on general practitioners, as proposed under **Objective 2**, 'Right-touch regulation'.
- We are interested in the proposition of an Accredited Register as part of a broader health workforce regulatory regime, as this could be a feasible avenue for several allied health professions, including WHM. Currently, consumers cannot make their own choices about managing their health needs unless they are wealthy enough to pay out of pocket. If an Accredited Register can provide pathways for funding for professions currently not regulated under the HPCA Act, then this would support consumer choice and patients' needs and safety, including cultural safety. It could also remove some of the current inequalities across health professions, particularly in relation to registration fees and access to funding for professional allied health services.
- **Objective 3** addresses the current heavy financial burden related to implementing the HPCA Act, which is on the shoulders of individual professions regardless of their size and ability to recuperate these high regulatory costs. In some other Western countries, such financial burdens are not carried solely by professions but by the overall health system, as it is acknowledged that practitioners deliver essential public health services. The equity concerns raised regarding the current system are real and significant.
- The current regulatory system hinders patients from equitably accessing health services if a profession is too small to afford statutory regulation under the HPCA Act. This is despite there being many smaller allied health professions that can contribute significantly to patients recovering from illness and remaining well. NZAMH has long advocated that under the current regulatory system professions should be bundled under an RA to reduce duplication of administration costs. For example, an RA (or similar) for complementary, alternative, and traditional medicine professions could provide a significantly more cost-effective service than an RA for each profession. Our perspective is that RAs should not be self-funded by the professions but should be part of the infrastructure of the New Zealand public healthcare system so that professions can focus their resources on education and supporting delivery of high-quality services to meet consumer and community health needs, including the protecting and upholding of people's physical, psychological, social, and cultural

safety. Professions that meet the criteria for regulation should not be disadvantaged because they have a smaller number of practitioners.

- Accredited Registers supported by a state-sponsored workforce regulator could be a more sustainable, right-touch approach to regulating professions delivering lower-risk services. In our opinion, an Accredited Register approach is far preferable to and more workable than negative licensing. Administrative and stewardship functions provided by the Ministry would, if carefully designed, greatly assist RAs to run efficiently and effectively, and help ensure consistently robust standards of safety and quality of health care across regulated professions.

Key Questions

What is the best mechanism to empower practitioners to deliver services in line with their full competence? Do scopes of practice play a role?

Scopes of practice play an important role in laying out the standard activities a health care practitioner can competently and safely perform as a practising member of their specific profession.

As every health practitioner will develop their experience and practice differently over their professional life, there needs to be a way for individuals to record and have recognised additional validated competencies, so that they continue to be able to practice to their full potential.

How is it possible to safely increase the range of services that can be provided in areas where there are staffing challenges/shortages (e g rural areas)?

Regulation of allied health professions in some form would instantly provide access to hundreds of competent health professionals currently hampered by the lack of recognition of their profession in the public health service. This would provide a more flexible, adaptable, better resourced, and equitable health service, and provide greater choice for consumers.

How can regulation encourage (or facilitate) practitioners to broaden their levels of competence outside their professional scope?

This could be done through providing some type of financial assistance for further education and/or training, and by establishing a system whereby a practitioner can have added competencies recognised and recorded, enabling them to expand their practice across their extended scope.

How is it possible to assist commissioners of services by providing more certainty about the capability of individual practitioners?

A requirement of regulated health professions should be robust education, competency, and ethical standards. Every registered practitioner should be a member of a relevant professional body to ensure they meet minimum requirements. Validated additional competencies should be recorded for individual practitioners and these records be available to assure commissioners of services that practitioners are capable.

How can "lower risk" be defined? What needs to be taken into consideration?

Risk can be related to practitioner, product, condition, or treatment method. For example, the risk associated with WHM practice can be related to the use of herbal medicines:
- Without sufficient assessment and quality assurance of the product or plant being used.

- By an inadequately trained person.
- In an inappropriate way: inappropriate herb, dose, or method of treatment.
- For a condition or in a situation where a different treatment is warranted e.g. surgery.

All potential risk areas such as these should be considered individually and together when assessing overall risk of a profession. Establishing scope/s of practice and ensuring professional body membership to ensure continuing professional education and/or supervision requirements are met, also intrinsically contribute to lowered risk.

Given Accredited Registers would be voluntary, what benefits would make forming/joining an Accredited Register worthwhile (for the profession practitioner)?

The public could be assured that registered practitioners met minimum standards of education and competency, thus making the choice of a registered practitioner clearly preferential. Presumably the regulating body would also provide an avenue for complaints, thus providing extra assurance to consumers. The importance of this assurance for the public should not be underestimated. Currently a member of the public has to complete their own due diligence regarding competency, however given the nature of self-regulation, it is very difficult for self-regulating bodies to achieve the reach required to educate the public on how to find a competent practitioner.

We would also expect an Accredited Register to integrate those professions included into the public health system, enabling equitable patient access, funding, and also to certain tools of trade currently scheduled. For example, we would expect WHM practitioners to be the health professionals able to prescribe certain herbal medicines currently scheduled e.g. *Artemisia annua* extracts made in the traditional manner.

Protection of title would also provide significant incentive for practitioners to be registered.

Could an Accredited Register, endorsed by a regulatory body to self regulate, be a suitable model to ensure quality and safety of traditional medicine and connect traditional medicine to the wider health system?

Yes, we consider that if carefully designed, an Accredited Register could provide effective regulation that would improve consumer access to safe and effective WHM and other allied health services.

What is the role of professional/clinical expertise in regulation? How can these roles be retained through a more efficient structure?

Practitioners of a profession hold the greatest knowledge and understanding of that profession. Standards and competencies, practice requirements, and continuing professional development expectations should be guided by experts in each profession working through their relevant professional body. However, as the 2024 Canadian Health Workforce Network Health Practitioner Regulation Systems review discusses, there is a risk that delegating all regulatory functions to representative professional bodies risks perceived conflict of interest and a lack of objective oversight. A regulatory system should require input and oversight by both professional associations and the Government, to ensure the regulatory structure is practical, enabling, and robust.

The establishment of an administrative service within the Ministry and stewardship by it for the purposes laid out in the discussion document could greatly improve efficiency, whilst enabling professions to continue to contribute to regulatory functions where practical knowledge of a profession is essential. It would be important that high-trust relationships were fostered between the Ministry and professional bodies to minimise any perception of overreach.

How can the regulatory structure support decision making that responds to changing health needs/developing technology/more complex delivery models?

A regulatory structure that provides for umbrella services could include the development of an online centralised learning management system for regulated health professionals. This would provide an up-to-date record of a practitioner's scope of practice and could provide a source of information as to who is qualified/competent to perform particular health services, allowing efficient and rapid response by the health system when required. It could also provide valuable information as to where gaps in health provision lie, and efforts could consequently be made to encourage training in the relevant areas by new or existing professionals.

Which regulatory functions can be shared/consistent across professions, and which must remain profession specific?

Designation of those health professionals who may prescribe any scheduled or otherwise restricted tools of trade, and any changes to these, must be considered profession by profession and be overseen by both the relevant professional association and the Ministry.

Complaints and disciplinary procedures, registration management, and setting minimum clinical, ethical, and cultural standards could be shared across similar professions (for example traditional and complementary medicine professions) or possibly even more widely across the regulated health professions. Any profession-specific standards that are additional to the minimum standards and that are deemed necessary could be set in consultation with the relevant professional body.

The administration of a learning management system would also best be undertaken within the Ministry, as one of its major strengths would lie in there being an accessible record of the scope of practice of every regulated practitioner.

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Summary of RA workshops:

Regulatory shift:	Group 1 (Monday 29th July 2024):	Group 2 (Wednesday 31st July 2024):
Introductory comments	• MoH clarified this is not a review of RA performance; RAs are doing what the HPCA Act sets them up to do. • Health workforce regulation is more than the HPCA Act (e.g. Health and Disability Commissioner Act 1994). RAs are not the only regulator in this space (e.g. Medsafe - Medicines Control for pharmacists). • Need to be clear about what is meant by 'regulatory settings'. This will mean different things to different stakeholders (e.g. employers vs. practitioners vs. patients). • Ongoing challenges with disciplinary processes: o Need for timely appointments to the HPDT. o Long periods of time without hearings. o Recognition of the need to strengthen the relationship between RAs and the HDC.	• Education of the public has a vital role in promoting interdisciplinary models of care. The public need to be assured that it's okay to see different types of health practitioners. • Education institutions have a role in teaching practitioners about cross-profession service delivery → accreditation standards. • MoH is open to new way of solving the issues.
1 (Approach to scopes of practice that empowers practitioners)	• Broad scopes of practice require good credentialling at the employer level (noting, however, that currently not all employers conduct credentialling). • Employers don't always understand a practitioner's scope of practice. This can limit what functions they will allow a practitioner to perform. Similarly, employers may ask a practitioner to do something outside their scope of practice and may have vested interests. • Need for practitioners, employers, and regulators to have a shared understanding of scopes of practice. • Important that scopes can change over time (e.g. to developments in technology, equipment, etc.).	• The HPCA Act already allows for inter-professional scope development (e.g. the medical and dental professions share a scope of practice). • The HPCA Act is a very enabling piece of legislation. • For a scope of practice to be enabling, it should be described using principles. It isn't practical to describe scopes by specifying each task a practitioner can perform. • Concerns re. employers making decisions to do with scopes of practice: o There may be a conflict of interest (e.g. financial incentives).

	• Standardisation of scopes of practice (e.g. language and format) to improve consumer understanding.
	• Considerations re. "practitioner scope decisions are best made between employee and employer":
	  ○ Practitioners who are self-employed.
	  ○ Employers don't necessarily have the clinical knowledge to make these decisions.
		○ Employers don't necessarily understand scopes of practice. Position descriptions will sometimes specify things that are outside a practitioner's scope of practice. A power imbalance means practitioners are unlikely to dispute position descriptions that can lead them to practice outside their scope.
		○ Personality considerations – what if the relationship between an employee and their employer was to deteriorate?
		• Scopes of practice are not the only barrier – even if a scope is broad/enabling, there are other barriers stopping practitioners from working at top of competency (e.g. IMAC in the case of vaccinating).

2 (Alternative form of regulation)	• An intermediate tier of regulation may be good for professions with less risk and a small number of practitioners.
	• An intermediate tier of regulation could be used as a 'stepping stone' for certain professions – opportunity to move in and out of a profession (e.g. for students who don't finish their training but have certain competencies).
	• Health literacy is important. An intermediate tier would only work if the public/consumers understood the system.
	• It isn't the role of the regulator to regulate for professional recognition/mana. Regulation is about public safety and the risk of harm to consumers.
	• Could also consider if any professions currently regulated under the HPCA Act might be better suited to regulation via an intermediate mechanism.
	• Critical that there is a clear understanding of risk and how it's assessed. Some considerations:
		• Discussion on the meaning of risk:
		  ○ There are two parts to risk: (1) clinical competency and (2) practitioner conduct/behaviour.
		  ○ Risk emerges from the interactions between a practitioner and other elements of the system (e.g. employer expectations, physical environment, actions taken by colleagues, etc.). As these elements are not in the regulatory remit, feedback was given that regulation isn't an efficient format to address where these areas of risk lie.
		  ○ The public have a different understanding/expectation of risk to practitioners.

	○ Public health risk – risk to populations, not just individual consumers. ○ Important to reflect direct and indirect harm. ○ Risk profiles change over time. ○ Is the risk associated with the product or the practitioner (e.g. herbalists)? • The bottom end of the HPCA Act could be made more permeable, so that lower-risk professions could move into and out of the regulatory framework depending on their risk profile at a particular point in time. This would provide more flexibility in responding to changes in risk over time. • Do some professions appear low risk because the regulatory framework is working as intended? • Mental health is an area that might benefit from an intermediate tier of regulation – there are a number of different professions working in this area, and consumer understanding of the differences between these professions is poor. • Could also consider negative licensing. • What can we learn from the UK's accredited register experience?	• Question whether an intermediate tier would proliferate the number of regulatory bodies and make more bureaucracy. • Unclear the level of risk that an intermediate tier is expected to manage. • Whether or not an intermediate tier of regulation would appeal to certain professions will depend on what exactly this tier provides/looks like. • An intermediate tier of regulation could serve as an on-/off-ramp for certain professions (e.g. midwifery – number of students dropping out before completing degree).
3 (Responsive and efficient regulatory structure)	• MoH noted that all options are on the table. • Would a centralised approach to discipline be appropriate (e.g. challenges currently facing the HDC)? • Need to consider what functions could be shared across professions (e.g. IT systems, digital infrastructure) vs. functions that are profession-specific. Also necessary to account for the different risk profiles of professions.	• The money required to publicly fund a health practitioner disciplinary system would be massive. • The case for the financial viability of merging RAs is not clear. • Centralisation may reinforce Western, medical models of care. There is a risk of losing alternative care models because of centralisation. This could be mitigated by considering how professions are grouped under RAs.

	• Recognition that the negotiation power of smaller RAs is minimal. • The consumer should be at the centre of the regulatory structure. • MoH noted that change is required, including the need for greater (but proportional) accountability built into the legislation and opportunities for alignment across professions. • Suggestion for there to be a provision in the HPCA Act that allows for the appointment of co-Chairs. • Consider increasing the number of laypersons and Māori on RA boards, and appointing members of other health professions. The definition of 'layperson' needs refinement. • There needs to be a more direct relationship between Government/MoH and the RAs (e.g. notion of secondary/tertiary direction that is a level down from Pae Ora). • Look at the AHPRA model and consider what has and hasn't worked well.	• Policy, legal and IT are examples of services that could be shared across RAs. • Vital that professional identity is considered and accounted for. • Desire for there to be more information sharing and transparency between the Ministry and RAs. • Benefits of RAs developing and setting shared definitions for certain concepts (e.g. cultural competency, patient safety, etc.). • MoH acknowledged its initial preferred structure was a crown entity to regulate the health workforce, but has taken a step back to consider alternative structures that would deliver on the outcomes it is seeking. • Suggestions were made to look across the landscape of the health system and the environments in which multi-disciplinary teams operate and identify where the levers for improvement already exist and not yet leveraged. Specifically, that clinical governance frameworks could be explored as a place to lift the effectiveness and performance of multi-profession teams.

Closing comments/actions/next steps	• Thankful for the open and honest conversation.
	• Actions/next steps:
	  ○ MoH will provide RAs with a written summary of the two workshops.
	  ○ Agreement to use existing RA/MoH communication channels to continue conversation.
	  ○ MoH is considering its proposed engagement approach, including the timeline to release a public consultation document later this year, in light of feedback from RAs. In addition to RAs, MoH will be engaging with other key stakeholders in the development of the consultation document.
	  ○ If RAs have additional questions or would like to further discuss the proposals, they can contact Suzanne Townsend (email: suzanne.townsend@health.govt.nz).	

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Workshop attendees

Group 1 (Monday 29th July 2024):

- S9(2)(a), CMCNZ
- S9(2)(a), Dietitians Board
- S9(2)(a), MCNZ
- S9(2)(a), MCNZ
- S9(2)(a), MSCNZ
- S9(2)(a), MSCNZ & MRTB
- S9(2)(a), Midwifery Council
- S9(2)(a), OTBNZ
- S9(2)(a), OTBNZ
- S9(2)(a), ODOB
- S9(2)(a), Pharmacy Council
- S9(2)(a), Physiotherapy Board
- S9(2)(a), Podiatrists Board
- S9(2)(a), PBANZ

- Jay Andrew, MoH
- Joe Bourne, MoH
- Ben Clayton, MoH
- Steve Osborne, MoH
- Suzanne Townsend, MoH

Group 2 (Wednesday 31st July 2024):

- S9(2)(a) Chiropractic Board
- S9(2)(a), Chiropractic Board
- S9(2)(a), Dental Council
- S9(2)(a), Midwifery Council
- S9(2)(a), NCNZ
- S9(2)(a) NCNZ
- S9(2)(a), NCNZ
- S9(2)(a), NCNZ
- S9(2)(a), OTBNZ
- S9(2)(a), OCNZ
- S9(2)(a), Paramedic Council
- S9(2)(a), Paramedic Council
- S9(2)(a), Psychologists Board
- S9(2)(a), Psychologists Board

- Jay Andrew, MoH
- Joe Bourne, MoH
- Riana Clarke, MoH
- Ben Clayton, MoH
- Ramai Haeata, MoH
- Kim Meo, MoH
- Steve Osborne, MoH
- Suzanne Townsend, MoH

Stakeholder engagement list – Future of Health Workforce Regulation – Phase 1: Targeted Engagement

#	Stakeholder	Status
1	Chinese Medicine Council of New Zealand	Engagement held
2	Chiropractic Board	Engagement held
3	Dental Council	Engagement held
4	Dietitians Board	Engagement held
5	Medical Sciences Council of New Zealand	Engagement held
6	Medical Radiation Technologists Board	Engagement held
7	Medical Council of New Zealand	Engagement held
8	Midwifery Council	Engagement held
9	Nursing Council of New Zealand	Engagement held
10	Occupational Therapy Board	Engagement held
11	Optometrists and Dispensing Opticians Board	Engagement held
12	Osteopathic Council	Engagement held
13	Paramedic Council	Engagement held
14	Pharmacy Council	Engagement held
15	Physiotherapy Board	Engagement held
16	Podiatrists Board	Engagement held
17	Psychologists Board	Engagement held
18	Psychotherapists Board	Engagement held
19	Social Workers Registration Board	Engagement held
20	Hauora Taiwhenua	Engagement held
21	New Zealand Dental Association	Engagement held
22	Pharmacy Guild	Engagement held
23	Pharmaceutical Society of New Zealand	Engagement held
24	Allied Health Aoetearoa	Engagement held
25	New Zealand Association of Counsellors	Engagement held
26	College of Nurses	Engagement held
27	New Zealand College of Midwives	Engagement held
28	New Zealand Nurses Association	Engagement held
29	New Zealand Resident Doctors Association	Engagement held
30	Association of Executive Employees	Engagement held
31	Specialty Trainees of New Zealand	Engagement sought
32	Association of Salaried Medical Specialists	Engagement held
33	College of Midwives Union (MERAS)	Engagement held
34	Public Service Association	Engagement held
35	Tū Ora	Engagement held
36	Ngā Maia Māori Midwives Aotearoa	Engagement held
37	Te Ohu Rata O Aotearoa	Engagement sought
38	Te Ao Mārama – New Zealand Māori Dental Association	Engagement sought
39	Ngā Kaitiaki o Te Puna Rongoā o Aotearoa	Engagement sought
40	Te Kaunihera o Ngā Neehi Māori	Engagement sought
41	Tae Ora Tinana	Engagement sought
42	Te Ao Maramatanga	Engagement sought
43	Te Kāhui Rongoā	Engagement sought
44	Health Practitioners Disciplinary Tribunal	Engagement held
45	Health and Disability Commission	Engagement held
46	Health Quality and Safety Commission	Engagement held
47	Addiction Practitioners Association Aotearoa New Zealand (DAPAANZ)	Engagement held
48	Clinical Physiologists Registration Board	Engagement held

49	Hospital Play Specialists Association	Engagement held
50	Human Genetics Society of Australasia	Engagement held
51	Music Therapy New Zealand	Engagement held
52	Naturopaths and Medical Herbalists of New Zealand (NMHNZ)	Engagement held
53	New Zealand Association of Medical Herbalists	Engagement held
54	New Zealand Association of Professional Hypnotherapists (NZAPH)	Engagement held
55	New Zealand Audiological Society	Engagement held
56	New Zealand Orthoptic Society Inc. (NZOSI)	Engagement held
57	New Zealand Orthotics and Prosthetics Association	Engagement held
58	New Zealand Society of Diversional and Recreational Therapy	Engagement held
59	New Zealand Sterile Sciences Association	Engagement held
60	Nutrition Society of New Zealand	Engagement held
61	Speech-language Therapists' Association	Engagement held
62	Sport and Exercise Science New Zealand	Engagement held
63	Te Whatu Ora	Engagement held

Future of Health Workforce Regulation

Objective 1: People-centred regulation

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, cross-profession coordination; an interpretation of patient safety that also considers the impact of system factors; scopes of practice designed in line with service provision; and accountability mechanisms to ensure a quality workforce that meets patient needs. We have identified three outcomes to achieve this objective.

Interpretation of 'safety'

There is a growing view that system factors, such as shortages of health workers, may pose as great a risk to public safety as the standards applied to the workforce.[1,2,3] Our regulatory settings should consider the risk to patient safety posed by health services being unavailable or inaccessible. Decisions, such as those regarding the length of training programmes or registering overseas-trained professionals, should consider system need in addition to individual competence.

The burden of protecting and upholding people's physical, psychological, social, and cultural safety should be placed on the health system (of which practitioners are a part) rather than solely on individual practitioners themselves.

Outcome: Regulatory decisions consistent with community health needs

Reviews of health regulatory best practice raise concerns about the risk of 'regulatory capture' under governance arrangements where regulatory bodies comprise mostly elected members of the regulated profession. When key players wear multiple hats, roles and responsibilities can be blurred, checks and balances compromised, and risk of regulatory failure greater.[4,5,6,7,,9,10]

A 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 allowed for the promotion of interests of the professions over those of the public, compromising public trust.[11] The Ministry heard similar concerns about profession-based regulators in New Zealand during its 2023 engagements.

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

Optimising 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, limited access to health care, and concerns about quality and safety.

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.[12,13,14]

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: Greater system accountability

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

Currently, the only accountability mechanisms available to government are reactive and severe. More proactive and proportionate accountability mechanisms may address regulatory risks before they become issues, while maintaining an appropriate level of independent decision-making.

Greater accountability mechanisms can also help set clearer expectations for how regulators can account for health system needs in their processes and decisions.

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Objective 2: Right-touch regulation

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 incentives for professions to seek to be regulated under the HPCA Act beyond patient safety, such as access to funding. We have identified two outcomes to achieve this objective.

Outcome: Regulatory system proportionate to risk to public safety

Our current regulatory system does not reflect the diversity of services provided by professions regulated under the HPCA Act. As such, some occupational groups may be regulated by an RA when other regulatory models may provide sufficient public protection.

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 licencing[a] (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.[1]

Outcome: Broaden means to demonstrate competence

Currently, a practitioner's competence is determined largely on their formal qualifications. As important as this is to determine baseline standards, there are few mechanisms or incentives to develop skills beyond a professional scope of practice. This prevents optimal utilisation of the skills and capabilities of our health workforce and its responsiveness to local or emerging needs.

The 2024 WHO-commissioned review of global health practitioner regulation systems noted the importance of providing various means to recognise a practitioner's competence.

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. 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 support the culturally safe and community-based care that was so crucial to the COVID-19 vaccination campaign.

We want to consider how this responsiveness can be built into the design of our regulatory system. It could 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.

References and footnotes: Right-touch regulation

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a. Negative licencing is a more "reactive" type of regulation, where practitioners are not required to be registered but face sanction if they breach standards or codes.

Future of Health Workforce Regulation

Objective 3: Sustainable regulation

To be sustainable, a regulatory system needs to be fit-for-purpose not just now but into the future. In our current system, there is an expectation that 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.

Outcome: Transition to a more sustainable regulatory model

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

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.

We want to consider options for a more sustainable regulatory model to address current-state concerns raised and set the system up to succeed adapting to emerging needs in the future.

Future of Health Workforce Regulation

Regulatory Shift 1: An approach to scopes of practice that empowers practitioners to deliver services in line with their full competence

To meet the health needs of our communities, regulatory settings should empower the workforce to develop and utilise their skills to the greatest extent possible, and to deliver team-based models of care.

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 fosters inter-professional collaboration and team-based models of care.

The HPCA Act authorises RAs to describe a scope of practice 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.

Proposal: Specifying and upholding principles for professional scopes of practice in legislation

Providing greater clarity in scopes of practice with regards to the activities a health practitioner is permitted to perform, could create opportunities to improve the efficiency of how a service provider can utilise their workforce to meet health needs. Greater clarity of practitioner competence will enable commissioners of services to purchase health services more efficiently and provide greater consumer awareness.

There is an opportunity to explore principles that will ensure scopes of practice: are designed to recognise the full competence of a practitioner; identify shared areas of skills and capabilities between professions; provide the flexibility for practitioners to build competencies outside their scope; and provide a clear description of the competencies within the scope of that profession.

Proposal: Empower practitioners to deliver services in line with their full competence

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.

Evidence suggests that decisions about a practitioner's scope of practice are often best made at the local level via formal credentialling, or between employer and employee, rather than through centralised regulatory control[1,2,3]. This would allow the practitioner to hold a bespoke scope of practice, taking into consideration, among other things, their qualifications, skills, competencies and experiences, to enable them to meet the specific needs of their local community.

This is not dissimilar to an existing approach in the nursing profession, where registered nurses are empowered to take responsibility for 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.

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Regulatory Shift 1: An approach to scopes of practice that empowers practitioners to deliver services in line with their full competence

Benefits and opportunities

Consumers

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

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

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 multi-disciplinary care.

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

Recognising the full competence of practitioners will provide more flexibility for health service providers to design models of care that can meet the needs of consumers, and enable them to maximise the potential of their workforce.

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

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

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.

Formal recognition of skills 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

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. The proposed regulatory shifts would create an environment that enables and encourages professional development in response to local health needs.

Inserting principles into the legislation to guide the development of scopes of practice is unlikely sufficient to guarantee a change. There is significant risk that the intended benefits of these shifts will not be realised without making the improvements outlined in Regulatory Shift 3.

Regulatory Shift 2: An alternative form of regulation for lower risk services

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 incentives for professions to seek to be regulated under the HPCA Act beyond patient safety, such as access to funding.

Proposal: Establish an Accredited Register system for lower-risk professions

Establishing 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, is one way to provide a more proportionate regulatory model.

Accredited Registers are voluntary registers that set standards for practitioners working in health and care occupations not subject to statutory regulation. 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.

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

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 and employment law.

Other forms of regulation that could provide a less burdensome alternative to statutory regulation include negative licencing[a].

a. Negative licencing is a more "reactive" type of regulation, where practitioners are not required to be registered but face sanction if they breach standards or codes.

Regulatory Shift 2: An alternative form of regulation for lower risk services

Benefits and opportunities

Consumers

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.

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

Practitioners

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.

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

Service providers

An intermediate level of regulation may provide a mechanism to resolve regulatory threshold questions such as the regulation of assistant professions like midwifery assistants and psychology 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

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

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 may 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.

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.

Future of Health Workforce Regulation

Regulatory Shift 3: An efficient and responsive regulatory structure that reflects an inter-disciplinary approach to health service delivery

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.

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

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

This level of connectedness was envisioned when the HPCA Act was enacted, but implementation has been inconsistent across professions.

Profession-based regulators often 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. In New Zealand, it has also led to an inequitable system where Annual Practising Certificate (APC) fees vary widely between professions.

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.

Functions and principles

We are looking to explore how to apply principles such as consistency across professions, accountability to the health system and responsiveness to community needs to all regulatory functions, while maintaining that patient safety is paramount, decisions are evidence-based, professional identity is retained and regulation does not unnecessarily restrict access or stifle innovation.

RAs have made progress towards these principles in different ways. We would like to consider how we can see that progress applied consistently across professions and regulatory functions.

Regulatory functions	Principles
Registering practitioners	Patient safety is paramount
Accrediting courses and training providers	Decisions are evidence-based
Setting clinical, cultural and ethical standards	Professional identity and mana retained
Disciplinary processes	Not unnecessarily restrict access or innovation
	Consistency and cohesion across professions
	Accountability to the health system
	Responsiveness to patient need, including as a Tiriti partner

Future of Health Workforce Regulation

Regulatory Shift 3: An efficient and responsive regulatory structure that reflects an inter-disciplinary approach to health service delivery

Benefits and opportunities

Consumers

A more efficient structure could make it easier for consumers to find information on the health workforce, and a simplified pathway to raise complaints or other disciplinary issues.

Practitioners

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

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

Health system

A responsive and efficient regulatory structure could reflect 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.

A more efficient structure 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.

Equity

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 high needs groups.

What this may look like

There are many ways to establish an efficient and responsive regulatory structure, which we are keen to explore. They include:

Fewer, interdisciplinary regulatory bodies

This option proposes establishing a smaller number of cross-profession regulatory bodies and/or transitioning lower-risk professions to an accredited register (see Regulatory Shift 2) if deemed appropriate. Reducing the number of regulatory bodies could increase system efficiency, sustainability and cross-profession collaboration, but would not address accountability.

Establish an administrative service

An administrative service could be established within the Ministry of Health to support the stewardship function that is lacking in the current regulatory structure. This could facilitate proactive and collaborative regulation among RAs, streamline registration processes, and ensure consideration of patient voice in regulatory decisions.

Providing additional stewardship levers for the Ministry of Health under legislation

Legislation could be changed to provide to enable the Ministry of Health to more actively fulfil its health system stewardship function. This may include establishing the Ministry as responsible for managing, monitoring, overseeing, and/or providing strategic direction to the regulatory bodies.

Future of Health Workforce Regulation

Key questions

Regulatory Shift 1: An approach to scopes of practice that empowers practitioners to deliver services in line with their full competence

- What is the best mechanism to empower practitioners to deliver services in line with their full competence? Do scopes of practice play a role?
- How is it possible to safely increase the range of services that can be provided in areas where there are staffing challenges/shortages (e.g. rural areas)?
- How can regulation encourage (or facilitate) practitioners to broaden their levels of competence outside their professional scope?
- How is it possible to assist commissioners of services by providing more certainty about the capability of individual practitioners?

Regulatory Shift 2: An alternative form of regulation for lower risk services

- How can "lower risk" be defined? What needs to be taken into consideration?
- Given Accredited Registers would be voluntary, what benefits would make forming/joining an Accredited Register worthwhile (for the profession / practitioner)?
- Could an Accredited Register, endorsed by a regulatory body to self-regulate, be a suitable model to ensure quality and safety of traditional medicine and connect traditional medicine to the wider health system?

Regulatory Shift 3: An efficient and responsive regulatory structure that reflects an inter-disciplinary approach to health service delivery

- What is the role of professional/clinical expertise in regulation? How can these roles be retained through a more efficient structure?
- How can the regulatory structure support decision-making that responds to changing health needs/developing technology/more complex delivery models?
- Which regulatory functions can be shared/consistent across professions, and which must remain profession-specific?