Australasian College for Emergency Medicine

Australian and New Zealand College of Anaesthetists

College of Intensive Care Medicine of Australia and New Zealand

New Zealand College of Public Health Medicine

Royal Australasian College of Medical Administrators

Royal Australasian College of Surgeons

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

The Royal Australian and New Zealand College of Ophthalmologists

The Royal Australasian College of Physicians

The Royal Australian and New Zealand College of Psychiatrists

The Royal Australian and New Zealand College of Radiologists

The Royal College of Pathologists of Australasia

The Royal New Zealand College of General Practitioners

Royal New Zealand College of Urgent Care

Australasian College of Sport and Exercise Physicians

Council of Medical Colleges in New Zealand

5 April 2018

The Secretary
Health Select Committee
Parliament Buildings
WELLINGTON

To the Health Committee

Thank you for the opportunity to comment on the Health Practitioners Competence Assurance Amendment Bill. This response is from the Council of Medical Colleges in New Zealand (CMC).

Background

The Council of Medical Colleges in New Zealand is the collective voice for the Medical Colleges in New Zealand and through its members provides a well-trained and safe medical workforce serving the best interests of the New Zealand community. CMC brings together 15 Medical Colleges who provide support to over 7000 specialist medical practitioners working in a range of 36 specialties in the New Zealand health system. The Medical Colleges advise on workforce issues and advocate for appropriate quality health services in New Zealand.

The Colleges are accredited to provide Medical Council of New Zealand recertification programmes and therefore this is an important document for the Colleges.

This submission **collates the perspectives of several Member Colleges of CMC**, some of which will also be making their own submissions.

Introduction

CMC notes that this amendment bill is the culmination of reviews of the Act in 2009 and 2012. These included operational and policy reviews, but this Bill only addresses some of the issues raised in those reviews and therefore only results in selective changes.

Many of the 'operational' amendments have been taken from the 2009 review which was started in 2007 but little recent consultation has occurred with the RAs or groups of professionals they register to update the 2007 thinking, hence the changes address historic matters and do not address other issues RAs and others have raised.

In terms of "policy" amendments when the HPCAA was first introduced in 2003 – it was considered ground-breaking legislation, but time has moved on and professional regulation has also changed. It is now time to review and compare the Act against regulatory best practice internationally. This opportunity has been lost in the Amendment Bill.

Telehealth

It is noted the Bill does not address the issues of telehealth and in particular the lack of controls on health practitioners working across national boundaries. As CMC and some of its members have noted, the current Health Practitioners Competence Assurance Act 2003 does not empower the Medical Council of New Zealand to require overseas based doctors to register in the same way and to the same standard as New Zealand based practitioners must, this sets up a dual standard. Such doctors are now working in NZ without the regulatory controls and without requirements for cultural competence required of NZ based doctors.

This decreases the protection to the NZ public – the core purpose of the HPCAA.

Interim suspension

The Bill introduces a higher threshold for interim suspension (limiting this to where there is a reasonable belief that a "risk of serious harm" exists), which should be useful to enable the RA to act quickly where there are major concerns about patient safety.

However, this means a RA has to identify early on whether there is risk of "serious harm". This will be problematic if ongoing inquiry reveals greater risk than first thought in the Bill, because suspension is only possible where an initial test identified "serious risk".

It is reasonable that the Amendment Bill only allows interim suspension when the health practitioner has had a reasonable opportunity to make written submissions and be heard on the question, either personally or by his or her representative. Any suspension process must follow the tenets of natural justice.

New obligations to inform interested parties about decisions taken

Changes proposed that allow RAs to keep complainants, employers and business partners informed of decisions taken are sensible and in line with other areas of the Act, as long as reporting only applies to those mentioned in the current section 34 (1 and 2) i.e. other health professionals and the HDC.

Any extension of reporting provisions, for example reporting to complainants, employers and business partners in relation to **possible** competence and health concerns, needs careful consideration. If reporting clauses are too wide they will act as a disincentive to reporting competence and health concerns. They also will act as a disincentive to a practitioner agreeing to undergo a competence review or health assessment – if they consider the matter may become public knowledge especially if this is before the practitioner is found wanting in any way.

Power to order medical examination amended

It is appropriate so that a health examination can be performed by an assessor not only a "medical practitioner". This would enable the health of a practitioner to be assessed, by other allied health practitioner when appropriate.

In light of the above change it is suggested this clause is called "*Power to order a medical examination".*

QA Activities

There is no concern about reducing the administrative burden of reporting relating to quality assurance activities but extending the reporting time from six months to a year is a minimal change.

A report on how these provisions are being used /not used and why would be helpful to understand the clause change and to ensure that no other changes are

warranted.

Name suppression
In line with natural justice the naming of a practitioner should only occur when due process has been followed and an adverse finding has been made in relation to a health practitioner's conduct – and where publication of the practitioner's name will not have an adverse impact on others (in particular, victims of a practitioner's sexual offending).

This reporting is the purview of the Tribunal, not the RA.

In terms of **naming policies**, the intent of the amendment is not clear. The way the clause is written indicates there may be a push to name any practitioner undergoing a competence review or other RA process- not just for cases where a practitioner has been found guilty and has been disciplined by the Tribunal.

In the introduction of the Bill it was said that "*making authorities' decisions and orders……. available is going to be important*". If the intent of this clause is to extend naming policy to other process such as competence or health this would be a retrograde step and go against the principles of the Act – i.e. to ensure practitioners are competent to practise. If practitioners know any possible concerns they report about another doctor are likely to result in that person to be named this will lead to reduction of reporting of possible incompetent practice or health concerns. In addition, the practitioners themselves will be less likely to work with the RA to improve and be more likely to resort to lawyers to prevent the remedial processes. This goes against the purpose of the Act – which is to ensure practitioners are competent.

Inter-disciplinary collaboration and co-operation in the delivery of health services
This introduces a new "function" of RAs, "to promote and facilitate inter-disciplinary collaboration and co-operation in the delivery of health services." While it is beneficial for health professionals to work together, there are no details on how the RAs are to do this function and it is not related to the stated purpose of the Act and the focus for authorities i.e. ensuring competent practitioners.

This is an employment not a professional regulatory matter. One cannot legislate for teamwork.

Changes to the Section 118
It is agreed that that RA should receive and act on information from any persons about the practice, conduct, or competence of health practitioners.

One matter not addressed in the changes is the concern a practitioner may have when raising concerns about another practitioner – this could be assisted by an explicit statement in the Act about protection of a practitioner from liability if raising concerns "in good faith".

Performance reviews: Clause 28 introduces performance reviews of RAs.
Currently the Minister may ask for statistical information relating to the discharge of the RAs functions which means he or she already has the power to find out more information about an RAs discharge of its functions.

In terms of the clause in the Bill, about assessing the performance of the RA, it is not clear what "problem" is, that this clause (of requiring RA performance reviews five yearly) is being used to fix.

If this is to mitigate the public perception that the RAs are "there to protect the practitioner" rather than the health of the public. Then more information is needed on possible scope of reviews, if the reviewer is independent and the input the RA are able to have before the review and after any draft report is completed and who bears the cost.

These reviews have the potential to add costs without a clear benefit and any financial burden placed on RAs can only be met by increasing the fees that they charge practitioners. In turn practitioners will have to meet those costs either by raising the fees they charge patients, or by passing the cost to their employer (in the case of those employed within a DHB). In other words, the costs of conducting the performance review will ultimately be passed to either patients or Vote Health.

Costs of the Tribunal

It is accepted by RAs need to be responsible for meeting the administrative costs of the Health Practitioners Disciplinary Tribunal.

Amalgamation of RAs

While CMC is not opposed to the amalgamation of some of the smaller RAs after consultation is held and those impacted have agreed. Again, it is not clear what benefits this change of the Act will have. Overseas experience has suggested to get any substantial cost and efficiency gains the resulting RA will have to have large numbers (in excess of 100 000 practitioners).

With NZ small authorities this threshold is not able to be reached. In addition, it risks the very essence of the Act that of "professional regulation with public input" as the professional being regulated may get side-lined in a large multi profession RA.

It is noted that the RAs have already formed different servicing arrangements (such as the Osteopathic Council having a service agreement with the Nursing Council) and relational structures (such as several RAs being co-located). Therefore, it should be left to RAs to amalgamate where sensible and accepted by their practitioners.

Workforce data

Clause 29 places a new requirement on RAs to collect and provide the Director-General of Health with workforce data.

Some CMC members do not accept that collection of this information is within the core principles of the Act – to ensure "practitioners are competent to practise".

On the other hand, it is accepted to plan appropriately to deliver services for the public the Ministry of Health/HWNZ does require good workforce information and this is in the public good.

If this data is collected it should include ethnicity as increasing the Māori and Pasifika medical workforces is a priority for many colleges and for the Ministry of Health through HWNZ so that there is a more culturally competent health workforce and reduce inequity.

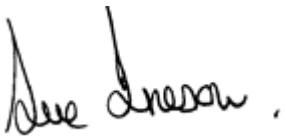
It is noticed that even if collection of work force data is accepted as part of an RA functions the Bill makes no changes to Section 118 the functions of RA to enable this or to the purpose of the Act section 3(1) to enable the RA to do this.

There are no new clauses to allow the RA to require the information from their

practitioners. Therefore, it is unclear how the RA will be empowered to require practitioners to provide the information or what will happen if practitioners do not provide it I.e. the clause gives no obligation on the authorities to actually ask for it and no obligation on practitioners to provide it. No changes to section 149 on registers are being proposed in these amendments that could allow this. Therefore, the clauses on workforce data collection do not seem to have been well thought through.

We trust the above comments are helpful.

Yours sincerely



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