30 October 2012

HPCA Act Submissions
Health Workforce New Zealand
National Health Board
Ministry of Health
PO Box 5013
WELLINGTON 6145

Dear Sir/Madam

2012 Review of the Health Practitioners Competence Assurance Act 2003

Thank you for inviting my comments on the Ministry of Health's 2012 review of the Health Practitioners Competence Assurance Act 2003 (HPCA Act).

In preparing my comments, I have referred to submissions my Office has made in relation to past reviews of the HPCA Act. I **enclose** those submissions for your reference, and endorse the comments contained therein.

Introductory comments

HDC Role

As you are no doubt aware, my role as Health and Disability Commissioner is to promote and protect the rights of health and disability services consumers, as set out in the Code of Health and Disability Services Consumers' Rights (the Code). The Code sets out the rights of health and disability services consumers and the corresponding obligations on the providers of those services. The duties in the Code apply to registered and unregistered health and disability service providers.

One of my functions under the Health and Disability Commissioner Act 1994 is to make public statements about any matter affecting the rights of health and disability consumers. In my view, the review of the HPCA Act is a matter that affects such rights.

HDC Vision

During my time as Health and Disability Commissioner, I have been sending a clear message to the sector of my vision for health and disability services in New Zealand. That vision is a consumer-centered system; a system built on the concepts of seamless service, patient engagement, transparency, and an empowering culture. Accordingly, I support steps to strengthen the HPCA Act in accordance with the principles of care integration, safety and the central role of the consumer; all principles that the Ministry has used to guide its review.

Support for HPCA Act

At the outset, I note that I strongly support a robust regulatory system for the regulation of health practitioners in New Zealand. The HPCA Act is fundamental legislation in terms of protecting the safety of health and disability consumers by ensuring that health practitioners are competent and fit to practise. There are, however, some key areas in which I consider further improvements could be made, and I discuss these below. I have arranged my comments in accordance with the four principles the Ministry has used to guide its review.

Future focus

Integration of care

The Ministry is seeking to achieve the best outcomes for patients through integrated care, and has asked how the HPCA Act can improve health professional regulation to keep pace with this.

I agree with the Ministry that care integration is an important factor in quality service provision, and that quality and safety are becoming increasingly dependent on how multidisciplinary teams and clinical networks operate. Failure or inadequacy in care integration is a recurring theme in complaints to my Office, which often result in consumers receiving a poor standard of care. As I pointed out in a recently published opinion,[1] in any healthcare system, there are a series of layers of protections and people, which together operate to deliver seamless service to a consumer. When any one or more of these layers do not operate optimally, poor outcomes result and consumers are at risk of being harmed.

The Ministry has noted in the consultation document that the HPCA Act focuses on the competence and accountability of individual clinicians in teamwork situations. However, the Ministry also considers that a complementary focus across health professions is necessary to address common sources of error and inefficiency involved in professional communication and collaboration. I agree. The question is whether this is a matter that can be addressed by the HPCA Act and, if so, how.

In the current regulatory framework, the importance of care integration is recognised in Right 4(5) of the Code, which gives consumers a right to cooperation among providers to ensure quality and continuity of services. This applies to cooperation both intra- and inter-professionally, across multi-disciplinary teams. In my view, communication and cooperation between providers, comprehensive documentation, and the involvement of the consumer are key to successful care integration. I encourage health practitioners to ask questions and raise concerns with each other, including across disciplines, and all administrators and staff (registered and unregistered) to maintain a culture that both allows and encourages such interactions.

Accordingly, the Code currently imposes a responsibility on both registered and unregistered service providers to cooperate with each other to ensure quality and continuity of services. The HPCA Act could potentially improve health professional regulation to further support integrated care by promoting standardised competencies in the areas pertinent to successful care integration.

[1] Opinion 09HDC01883, 15 June 2012.

In respect of standardised competencies, I note that the principal purpose of the HPCA Act is to protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions. However, there is no definition of "competence" or "fitness to practise" in the HPCA Act. Section 16 refers to "fitness for registration", and there is a requirement under section 16(1)(a) that a registrant must be able to "communicate effectively for the purposes of practising within the scope of practice in respect of which the applicant seeks to be … registered". However, this section has limited value in respect of promoting care integration as a core competency. While some responsible authorities have comprehensive documents setting out basic professional competencies, for example, the Midwifery Council of New Zealand and the Nursing Council of New Zealand, others do not.

The review of the HPCA Act provides an opportunity to consider the value of prescribing core competencies for all health professions, to support care integration. This could be by way of an amendment to the HPCA Act to prescribe that each responsible authority must issue a statement of basic competencies, which would include, for example, the core competencies of effective communication and cooperation between providers, promoting consumer engagement and self-management, and comprehensive documentation. These are issues frequently raised in complaints to my Office regardless of a health practitioner's profession, and in my view, are core competencies that all health practitioners should demonstrate if they are competent and fit to practise in their profession.

HPCA Act promotion of education and training

The Ministry asks how the HPCA Act can promote education and training that has a wider focus, such as effective ways of working in teams, improved communication skills, and support for consumer self-management.

Part 3 of the HPCA Act provides mechanisms for ensuring the competence of "a" health practitioner, and is activated only where a concern has arisen. The current provisions relating to the education of practitioners concern only the education programmes for qualification, and do not specifically address ongoing education or professional development. While generally all responsible authorities recognise the central role of continuing professional development, there is potential for the HPCA Act to require health practitioners to engage in continuing education and training to maintain their competence and fitness to practise.

It is important that training programmes across all responsible authorities equip health professionals with the necessary skills and knowledge to ensure they provide services of an appropriate standard. This includes ensuring health practitioners are aware of their obligations under legal, ethical and professional standards, including the Code. While the training needs of health practitioners will differ across the professions, there are some training areas common to all professions (including in relation to the core competencies discussed above). In those areas, the HPCA Act could require the responsible authorities to ensure that frequent courses are available and require that ongoing education and training, including in the areas of core competencies, be a prerequisite to registration and re-registration by the responsible authority.

While each profession will have its own specific education and training requirements, I support responsible authorities sharing information and resources for education and training in areas where there is overlap. In addition to education and training in core competencies, this may include, for example, education and training on learning from complaints, on the management of high risk health professionals, on international developments in health, and on administrative efficiency.

Pastoral care
The discussion document asks whether responsible authorities should have a mandated role in the pastoral care of their registrants. In my view, the health and fitness to practise provisions under sections 45 to 51 of the HPCA Act are sufficient. The professional associations, such as the New Zealand Medical Association, the New Zealand Nursing Organisation, and the College of Midwives also offer practitioners professional support.

Consumer focus
As noted in my introductory comments, my vision for the sector is a consumer-centred system, which involves sharing information and understanding, engagement between provider and consumer, quality and continuity of care, a supportive and transparent environment – all of which are underpinned by respect for the consumer and their values and preferences, and the role of the consumer's family.

However, the HPCA Act should be careful not to place a disproportionate responsibility on the consumer. Ultimately, protection of consumers is not achieved through a statute, but relies on those organisations and individuals who are responsible for educating, training and reviewing health practitioners. There is also individual responsibility that lies with the health practitioners themselves.

Competence reviews
The discussion document asks whether the HPCA Act keeps the public safe. I consider that some improvement could be made in the area of competence reviews by responsible authorities. In my view, the HPCA Act should provide a lower threshold for competence reviews, and allow for responsible authorities to take more prompt action on competence concerns, in the same way that they are able to when health concerns are raised about a practitioner. Under section 39 of the HPCA Act, authorities can only order an interim suspension of, or impose interim conditions on, a health practitioner's practising certificate if there is a "risk of serious harm". In order to keep consumers safe from potentially harmful practitioners, I suggest that the threshold in section 39 be lowered to simply "a risk of harm".

Information sharing
The discussion document asks questions about the adequacy of the transparency of information and processes to the public, particularly as it relates to complaints and complaint processes.

There is a discrepancy between the public's ability to access information held by my Office and that held by responsible authorities. My Office is subject to the Official Information Act 1982 (OIA), and handles regular requests for information from both the public and the parties to complaints. However, responsible authorities are not

subject to the OIA. This results in an inconsistency between the transparency of the HDC and responsible authorities' complaints processes.

If I refer a complaint to a responsible authority under section 34(1)(a) of the Health and Disability Commissioner Act 1994, and the responsible authority undertakes a review of the practitioner's competence, the consumer will often not be provided with information about the outcome of the responsible authority's consideration of their complaint or the outcome of any review undertaken in response to the complaint. In these cases, a consumer will often asks my Office for information about the outcome of the review. Clearly, details about the outcome of a responsible authority's consideration of a complaint or of a competence review is information that is more closely connected with the functions of a responsible authority. It would therefore be desirable for my Office to be able to transfer such requests for information to the responsible authority under section 14 of the OIA. However, under the current scheme, my Office is obliged to give access to that information, unless one of the withholding grounds under the OIA applies. Ideally, in the interests of transparency and consumer engagement, the same principles of availability of information about complaints should apply to both HDC and responsible authorities.

Consumer input

The discussion document asks whether to introduce consumer forums, so that the public can communicate with responsible authorities on matters that concern them. In my view, this would be an excellent development. An increase in the number of consumers involved in responsible authorities' processes, and on Boards, should also be considered.

HDC's Consumer Advisory Group advises my Office on:

- the handling of consumer complaints about health and disability services;
- how to improve the quality of health and disability services;
- public interest issues where HDC can take a lead;
- policy issues raised by the Commissioner; and
- promotion and education.

The Consumer Advisory Group also provides advice to the Medical Council of New Zealand on matters concerning the Council's functions. In my experience, the voice of consumers is an indispensable means of improving both service provision and mechanisms for complaints resolution.

Safety focus

Regulation under the HPCA A ct

The HPCA Act's role in preventing harm to the public is complemented by my Office's functions. While the HPCA Act only governs registered health practitioners, I have jurisdiction to consider complaints about any person holding themselves out as providing health services to the public.[2] In reality, complaints about unregistered providers constitute a very small portion of the total complaints to my Office,[3] but my

[2] Health and Disability Commissioner Act 1994, section 3(k).

[3] In the 2011/2012 financial year, fewer than 3% of total complaints received by HDC were about unregistered providers.

ability to address the practice of unregistered providers is effective in closing some of the "gaps" presented by the registration scheme under the HPCA Act.

There are differences in the remedies available to consumers, depending on whether a provider is registered. Currently, if a provider breaches the Code, I can refer that provider to the Director of Proceedings (the DP). If a provider is registered, proceedings can be brought in either the Health Practitioners Disciplinary Tribunal (the HPDT) or the Human Rights Review Tribunal (the HRRT), or both. If a provider is unregistered, proceedings can only be brought in the Human Rights Review Tribunal (HRRT).

The HRRT can award compensatory damages for losses suffered and/or lost benefits (although typically awards are for injury to feelings, humiliation and/or loss of dignity) and the HRRT has the power under section 57(1)(d) of the Health and Disability Commissioner Act to award punitive damages if there has been a flagrant disregard of a consumer's rights. The HPDT does not have similar powers to award damages. In a small number of cases for matters that do not constitute a treatment injury, it may be necessary and/or appropriate for the Director of Proceedings to institute proceedings in the HPDT to hold a practitioner professionally accountable for a breach of the Code, as well as to seek damages for a consumer through the HRRT (for example, in cases concerning a breach of sexual boundaries). In these circumstances, it would be helpful if the HPDT could also award damages that would otherwise only be available in the HRRT. This would ensure a more efficient process, effective use of resources, and would reduce consumer and provider stress in needing to be involved in two separate proceedings.

The discussion document asks whether we can make better use of employer-based risk management systems and reduce reliance on statutory regulation. I support employers having a role in ensuring that their staff are competent and remain fit to practise, for example, through supporting continuing professional development and responding promptly when an employee's practice raises questions about his or her competence. However, it is arguable that there is an inherent conflict of interest in employer-based regulation, and for professions that carry a significant risk of harm, the role of the employer should not take the place of an external regulatory authority. The role of the employer can also be complicated in the case of practitioners who practise in several locations and between the public and private sector. In the previous Commissioner's Tauranga Hospital Inquiry, concerns were raised about the competence of a surgeon who worked at three hospitals – one public and two private. While two of the hospitals had taken steps to address concerns about his competence (including restricting his practice), the failure to share information with other hospitals (in part because of privacy concerns) meant that there was no coordinated response to the risk he posed to the public, and he continued to practise unrestricted at the third hospital. In that case, the employer response was insufficient to protect the public from the potential risk posed by that surgeon.

The discussion document asks for suggestions for how practitioners in sole practice can better manage risks related to their clinical practice. I note that it may also be appropriate for those in sole practice to be required to belong to a peer group and attend monthly "supervision" meetings.

Risk of harm
The discussion document asks whether the level of risk that needs to be regulated by statute is clear. Sections 34 and 35 of the HPCA Act require HDC and responsible authorities to promptly notify one another if there is reason to believe that a health practitioner may pose a risk of harm to the public. I note that the use of the word "may" means that there does not need to be proof of actual harm, which is helpful in terms of the requirement that notification must be "prompt".

"Harm" is not defined in the HPCA Act and I consider that the HPCA Act would benefit from clarifying what is intended by the use of that term. Without limiting the considerations which may be relevant to the assessment of "harm", in assessing such matters, my Office generally considers that a risk of harm may be indicated by:

- a pattern of practice over a period of time that suggests a practitioner may not meet the required standard of competence or conduct;
- a single incident that demonstrates a significant departure from accepted standards of practice;
- recognised poor performance where local interventions have failed;
- criminal offending; or
- professional isolation with declining standards becoming apparent.

This guidance is similar to that used by the Medical Council of New Zealand. In my view, the criteria used by every responsible authority should be clearly aligned.

Other areas for clarification
I note the comments in previous submissions by this Office in relation to some areas of uncertainty in the HPCA Act.

Conclusion
Overall, the HPCA Act is essential in protecting the health and safety of members of the public by ensuring that health practitioners are competent and fit to practise their professions. The HPCA Act, and the current review, has the opportunity to be instrumental in bringing about the kind of culture change that is necessary for health and disability services to become truly consumer-centred.

I am happy to elaborate further on my comments above, if that would be helpful. Otherwise, I look forward to hearing from the Ministry regarding the next step in the review process.