Submission

Putting Patients First: Modernising health workforce regulation

SPECIALTY TRAINEES OF NEW ZEALAND

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Specialty Trainees OF NEW ZEALAND

This is a reformatted copy of the online form submission made by Specialty Trainees of New Zealand Incorporated, STONZ, on 30th April 2025.

We are a not-for-profit union organisation that represents approximately half of the unionised Resident Medical Officer (RMO) workforce in Aotearoa, New Zealand.

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Patient-centred regulation

Faster wait times, better outcomes, and a system that truly puts patients first.

1. Would you be interested in having a say on any of the following?

- **Changes to scopes of practice (what health practitioners can do) and how this affects patient care**
- **Qualification requirements**
- **Other professional standards (for example, codes of conduct) that impact patient experience**

Yes, all three areas.

2. Are there any other things you think the regulators should consult the public on?

No comment.

3. Are there any health practitioners who are currently unregulated but should be subject to regulation to ensure clinical safety and access to timely, quality care?

STONZ is strongly opposed to the introduction of currently unregulated professions, such as Physician Assistants (PAs) in New Zealand. These professions do not represent a long-term investment in the health system. There are no, or limited, training programmes, and the utilisation of a predominantly overseas trained workforce unfamiliar with the Aotearoa New Zealand context is not supported. These professions have limited scope of practice and negatively impact junior doctor and other professional training.[1,2]

Using the example of PAs, they are currently required to work under close supervision and are precluded from performing certain tasks that pose the greatest risk to the health and safety of the public, such as prescribing medications. In STONZ's view, regulation would legitimise a workforce we believe should not enter healthcare more widely in Aotearoa New Zealand and will enable a widening of scope of practice and a reduction in supervision of PAs already residing within the country.

Research into PAs is limited, but studies from the USA have shown that when looking at the percentage of malpractice allegations related to misdiagnosis, which can be taken as a proxy marker of medical knowledge, physicians had significantly fewer (31.9%) than PAs (52.8%), with PAs having the highest rates of incorrect diagnosis-related complaints.[3]

PAs are a perpetual burden on the health systems, rather than a long-term investment.
In contrast, Resident Medical Officers (RMOs) undergo training and transition into the Senior Medical Officer (SMO) workforce. This transition not only allows RMOs to work independently but also enables them to train the next generation of doctors.

Clinical safety and access to timely, quality care is restricted not by access to a wider range of professions, but by adequate and equitable investment in our existing workforce. The purported benefits of unregulated workforces are not likely to outweigh the long-term negative effects to the New Zealand health system.

1. British Medical Association. BMA junior doctors committee and GP registrar committee statement on MAPs. Published online October 30, 2023. Accessed November 15, 2023. https://www.bma.org.uk/news-and-opinion/bma-junior-doctors-committee-and-gp-registrar-committee-statement-on-maps
2. Victorino GP. Physician Assistant Influence on Surgery Residents. Arch Surg. 2003;138(9):971. doi:10.1001/archsurg.138.9.971
3. Brock D, Nicholson J, Hooker R. Physician Assistant and Nurse Practitioner Malpractice Trends. Med Care Res Rev. 2017;74(5):613-624. doi:10.1177/1077558716659022

4. Do you think regulators should do more to consider patient needs when making decisions?
It is reasonable for regulators to ensure meaningful consumer involvement in regulatory activities. For instance, a requirement for patient and/or layperson representation within governance structures or consultation with representative consumer bodies. However, this is already standard across medical regulators, as mandated under the Health Practitioners Competence Assurance (HPCA) Act 2003. A patient's needs are best served by a high quality and well-trained healthcare workforce, and this cannot be compromised.

5. What are some ways regulators could better focus on patient needs?
Regulation ensures safe patient care at a high standard. The most effective way to prioritise patient needs is maintaining a high standard of healthcare workforce across New Zealand, ensuring adequate skills, qualifications, and cultural competence. This can be achieved by continuing with independent regulatory bodies composed primarily of healthcare professionals.

6. What perspectives, experiences, and skills do you think should be represented by the regulators to ensure patients' voices are heard?
STONZ supports the view that the majority of members of health regulatory authorities be health practitioners.

The consultation document states, "public views on regulation, for example on scopes of practice (what a particular health profession is allowed to do), should inform decisions." This statement is highly dangerous. The only individuals who should be making decisions on scope of practice are those who possess an in-depth understanding of the scope of practice; that is, those who have undergone training and worked within that scope of practice.

Furthermore, the document suggests that "the people making regulatory decisions need to understand the realities of a profession, but there are ways of gaining that understanding outside of working as a practitioner. When most members of an authority are practitioners, decisions are more likely to be based on the interests of the profession, which may not match the public interest." We firmly believe this is untrue. It is impossible to understand the realities of working in a profession without being actively involved in it. The advantage of having regulatory authorities composed primarily of health practitioners and independent of government is that decisions are made outside of the political realm, ensuring that they are made in the best interests of patients.

7. Do you agree that regulators should focus on factors beyond clinical safety, for example mandating cultural requirements, or should regulators focus solely on ensuring that the most qualified professional is providing care for the patient?
Yes, regulators should focus on factors beyond clinical safety, for example mandating cultural requirements.

The regulators should not focus solely on ensuring "the most qualified professional" is caring for the patient. Rather, they should focus on the most appropriate professional, trained to a high standard which is comparable throughout the country.

Ultimately, Te Tiriti o Waitangi is the founding document of Aotearoa New Zealand and gives legal obligation to culturally appropriate care. This must be considered in all aspects of healthcare, including regulation of practitioners, as a legal duty. Cultural requirements therefore must be considered by the regulators, as safe and effective care following the legal principles of Te Tiriti must be adhered to as set out in the 2022 Pae Ora legislation.

This consultation is about putting patients first, and the cornerstone of this is adhering to Te Tiriti principles for the good of all patients. Therefore, cultural safety is an intrinsic part of "clinical safety", and the two cannot be separated.

8. Do you think regulators should be required to consider the impact of their decisions on competition and patient access when setting standards and requirements?
No, the regulators' primary focus is ensuring that health practitioners are suitably trained, qualified, and safe to practice. It is the Government's responsibility to consider these impacts and work with all stakeholders in achieving health workforce goals.

Streamlined regulation

Using resources and administering the rules in the most cost-effective way possible, ensuring value for money for taxpayers and better outcomes for patients.

1. How important is it to you that health professions are regulated by separate regulators, given the potential for inefficiency, higher costs, and duplication of tasks?
Important.

Why?
Aspects of administrative, governance, regulatory and technical functions of the regulators could be centralised. The consultation provides the scenario, "I don't understand why we have 18 regulators, which is more than the UK or Australia? Is this an unnecessary cost and inefficient?" Whilst Australia and the UK may have centralised regulatory bodies, they still have independent professional boards or sub-committees that regulate each profession (e.g. the Australian Health Practitioner Regulation Agency or Health & Care Professions Council).

We support that each health profession maintains a national board that is responsible for their core respective regulatory activities, irrespective of overarching governance or centralisation.

2. To help improve efficiency and reduce unnecessary costs, would you support combining some regulators?
Yes.

Comments:
See our above comment. In summary, we support that each health profession maintains a national board that is responsible for their core respective regulatory activities, irrespective of overarching governance or centralisation of administrative processes.

Right-sized regulation

The level of regulation should depend on the level of risk to public safety involved.

1. Do you agree that these regulatory options should be available in addition to the current registration system?

- **accreditation** - No
- **credentialling** - Yes
- **certification** - Yes

For credentialing/certification, we support these regulatory options, but only in addition to standard regulatory processes and restrictions. For example, as has been demonstrated with the National Pelvic Mesh Credentialing Scheme for consultant surgeons.

The consultation defines accreditation as "the Government could accredit a currently 'self-regulated' professional body to carry out regulatory functions, with government oversight. This might be suitable for speech and language therapists, for example, whose association currently operates similarly to the health workforce authorities." We do not support this, as the example provided acts a regulatory body disguised as another entity, while simultaneously undermining normal regulatory processes.

2. Do you think New Zealand's regulatory requirements for health workforce training, such as the requirement for nursing students to complete 1,000 hours of clinical experience compared to 800 hours in Australia, should be reviewed to ensure they are proportionate and do not create unnecessary barriers to workforce entry?

Yes.

Comments:

Yes, regulatory requirements should be subject to review to ensure they are aligned to comparable health systems. However, these are not simplistic reviews. In the documented example, there is no clear definition of what constitutes "clinical hours" or how they are to be calculated. Furthermore, workforce training cannot be quantified solely based on snapshot statistics.

3. Should the Government be able to challenge a regulator's decision if it believes the decision goes beyond protecting patient health and safety, and instead creates strain on the healthcare system by limiting the workforce?

Yes.

Comments:

Yes, this is reasonable. However, regulators should maintain independent decision making. Where there is disagreement, there should be a clear process and defined escalation policies, such as referral to a non-partisan, independent body.

4. Do you support the creation of an occupations tribunal to review and ensure the registration of overseas-trained practitioners from countries with similar or higher standards than New Zealand, in order to strengthen our health workforce and deliver timely, quality healthcare?
No.

Comments:
No, this proposal subverts the regulatory process. If there are concerns with this process, as outlined in our previous comment, the Government could challenge a regulator's stance through a transparent, independent process. The consultation suggests that the tribunal "would be able to overturn decisions by regulators not to register a particular practitioner." Regulators decide to not register a practitioner only when it is felt to be unsafe as their knowledge and qualifications do not meet the standards required to provide quality care to New Zealand patients. This decision is not made lightly and having a separate tribunal with the power to overturn these decisions could pose significant risks and borders on negligence.

The consultation acknowledges that "for many overseas-trained professionals, getting their qualifications recognised can be a lengthy and complicated process". This is with good reason. It is impossible to control the standard of education in other countries and therefore there are clear risks of unsafe and undertrained staff entering NZ healthcare. Additionally, people trained overseas will have limited knowledge of specific issues related to New Zealand. This has flow-on effects for culturally appropriate patient care, and our Te Tiriti obligations. We know that in New Zealand, many patients, especially Māori and Pasifika, often present with diseases that are less common in other parts of the world (such as rheumatic fever), and present later with more severe or atypical symptoms.

The consultation notes "while regulation is necessary for high-risk areas, the current one-size-fits-all approach creates too much red tape where the risk is lower." We would challenge this, as there is no such thing as "low risk" in healthcare. Safe patient care must be the highest priority.

5. Should the process for competency assessments, such as the Competence Assessment Programme (CAP) for nurses, be streamlined to ensure it is proportionate to the level of competency required, allowing experienced professionals who have been out of practice for a certain period to re-enter the workforce more efficiently, while still maintaining clinical safety and quality of care?
Yes.

If so, what changes should be made?
Yes, so long as it does not compromise clinical standards. Regulatory requirements should be subject to review to ensure they are aligned to comparable health systems. However, these are not simplistic reviews. In the prior example of nursing hours, there is no clear definition of what constitutes "clinical hours" or how they are to be calculated. Furthermore, workforce training cannot be quantified solely based on snapshot statistics.

6. Do you believe there should be additional pathways for the health workforce to start working in New Zealand?
No.

Comments:
No, there should be a single regulatory pathway for health workforce in New Zealand. Any other pathway will cause great patient risk and is in danger of subverting the intent behind regulation, i.e. to protect the public and to ensure high standards of heath care. Additional pathways act as a backdoor for less qualified staff members to enter the health workforce without adequate oversight.

Future-proofed regulation

Modernised and adaptive regulation that ensures patients receive the care they need while supporting the workforce to respond to the needs of all New Zealanders.

1. Do you think regulators should consider how their decisions impact the availability of services and the wider healthcare system, ensuring patient needs are met?
No.

Comments:
No, regulators must make decisions independent of the availability of services to ensure high quality health care. Patient needs are best met by safe practitioners working within a system where all are held to the same qualification. The public should not have to accept lower standards or substandard care.

2. Do you think the Government should be able to give regulators general directions about regulation?
Yes.

Comments:
Yes, but direction should not be binding. Government intervention could be seen as undermining the authority and trust of regulators and would represent the government taking over regulation by stealth. The government are not experts in regulation, and it is important that regulation is primarily dictated by healthcare workers within that workforce.

3. Do you think the Government should be able to issue directions about how workforce regulators manage their operations, for example, requiring regulators to establish a shared register to ensure a more efficient and patient-focused healthcare system?
No.

Comments:
No, workforce regulators should remain independent bodies with a non-partisan focus. Once again, regulators must be independent to ensure high quality health care. Regulation and standards for the health workforce should prioritise patient safety and should never have a political agenda. Regulators are funded by fees from the profession they regulate, which ensures their independence as a form of self-governance.

4. Do you think the Government should have the ability to appoint members to regulatory boards to ensure decisions are made with patients' best interests in mind and that the healthcare workforce is responsive to patient needs?
No.

Comments:
No, the Government should not have the ability to appoint members to regulatory boards. Again, regulators must be independent, to ensure high quality health care. Regulation and standard of the health workforce should be about patient safety; it should never have a political focus. However, the Government should be able to set general expectations regarding the diversity of regulatory boards, e.g. ensuring that there is layperson input (as is currently the case with the Health Practitioners Competence Assurance (HPCA) Act 2003). STONZ supports the view that the majority of regulatory board appointments be active members of the profession.