MEDICAL SCIENCES COUNCIL OF NEW ZEALAND
TE KAUNIHERA PŪTAIAO HAUORA O AOTEAROA

30 April 2025

Ministry of Health
By email: workforceregulation@health.govt.nz

The Medical Sciences Council of New Zealand has today submitted a response to the Ministry of Health consultation on *Putting patients first*. In addition to answering the specific questions in the consultation survey, we provide the following:

1. The Medical Sciences Council is a responsible authority under the HPCA Act. It regulates the professions of Medical Laboratory Science and Anaesthetic Technology with approximately 4,700 practitioners currently practising in the New Zealand health sector.

2. The following is a response from the Medical Sciences Council (the Council) to the consultation on the *Putting patients first* survey. This is separate to the response that has been provided through the online survey. The Council welcomes the opportunity to consider the current system of health practitioner regulation, and to propose changes that reflect the changing nature of clinical practice and the complex needs of people. It is of the opinion that any changes need to be informed by evidence and supported by robust and rigorous policy analysis. The responses provided in this document are aligned to the sections within the consultation document.

3. The Council is satisfied that its current regulatory mechanisms meet its obligations to protect the health and safety of the public. The Council's position is that the HPCA Act has served New Zealand well and that it provides a right touch, risk-based approach to the regulation of health professionals.

4. That is not to say that the Act cannot be modernised and strengthened to incorporate changes required. To support the future proofing of the regulation of health professionals, the Council has actively participated through the provision of advice and guidance, and in recent consultations that have been run by the Ministry of Health on the Act.

5. Modern regulators take a whole of system approach to their work and consider their role as part of the wider health system.

6. The Council also noted positive comments about the current health practitioner regulatory system made by the Minister in a recent Radio New Zealand interview (27/4/25) regarding the regulation of physicians associates.

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Patient Centred regulation

7. Patients are and should be at the heart of health care. Patient safety is the remit of regulators and those who are charged with this responsibility take it incredibly seriously. The voice of lay people and patients is an integral part of regulation and indeed within the current legislation at least one lay member is required for decision making to occur.

8. The Council supports strategies that place the patient at the centre of the healthcare system and where the patient has an active role in their healthcare experience. The Council has a key role in ensuring safety and the patients' experience through its role in ensuring that practitioners are competent and fit to practise, that they have the required knowledge, skills and attitudes.

9. Increasing the patient voice in the role of the regulator has been discussed by the Council, who are of the opinion that if this were to occur, then the how needs careful thought and consideration. While acknowledging that the way they currently operate has a good balance of professional and lay perspectives, the Council has noted that increasing the patient voice in regulation aligns with changes that have occurred within other jurisdictions where the number of lay people can equal the number of health practitioners on governance boards. For example, the HCPC in the UK. It noted that the UK model was implemented to ensure diversity of opinion when making critical decisions that affect patients and the public. It is therefore important that within the New Zealand context, there is a mix of knowledge, ability and experience to allow effective regulation to occur.

10. If increasing the patient voice means that more lay people are included around the board or governance table, then this needs to be balanced to ensure that the health professional voice and their knowledge, skills and expertise regarding professional practice is not lost. Ideally the board or governance body needs a skill set that reflects the lay experience, effective governance and professional practice.

11. Replacing practitioners with more lay people may require consideration of decision making to ensure that practice remains safe which is presently achieved through the balance provided with the current regulatory structure. This aside, the Council continues to be of the opinion that patient perspectives are welcome in consultations around scopes of practice, education qualifications and professional standards. All of these impact on the care that is, and can be, provided to patients and affect the patient experience.

12. What could and should be consulted needs to take into consideration the context and the environment in which practitioners work. There are already established ways in which lay involvement in consultation is achieved. This could be expanded through formal networks such as the Health and Disability Commission and the Health Quality and Safety Commission. There is also the opportunity for the responsible authority to consider how it promotes itself, for example reviewing its public facing website to be more attuned to the needs of the public and those needing the services of a health professional.

13. The responsible authority could also consider the development of its own networks/patient groups to hear directly from patients about their experiences. However, this needs to be taken into the context of each responsible authority and costs associated with the establishment of networks. Collaborative development of a lay person/patient forum for a number of responsible authorities could be one other way that these organisations work together and share resources and professional expertise.

14. Regulation must work in the public interest meaning that the regulation of practitioners must include consideration of the risks presented to the public and the consequences of the reality of regulation. The Council supports the regulation of practitioners when there is identified risk of serious harm, however it also supports processes like the development of an accredited register where the risk of harm is low.

15. It is imperative that regulators take a multi-view approach when defining the work of the practitioners. Clinical safety is more than technical competence. Taking a more than reductionist perspective on practice and considering the patient as more than simply their physical or mental health, means that regulators are providing the patient with an appropriately qualified and competent practitioner.

16. New Zealand and international evidence points to the importance of cultural aspects of care addressing inequality in health outcomes and the provision of safe care[1,2].

17. Complaints from the HDC and internationally reflect the significant role of effective communication in delivering safe health care. Cultural competence is one aspect of ensuring effective communication. Sixty-eight per cent of complaints to the HDC in the 2024 annual report had a communication issue identified[3]. In New Zealand, the government has undertaken reviews into effective communication with patients. The Health Quality and Safety Commission discusses the importance of ensuring health practitioners understand how to communicate with patients and their families effectively[4].

18. Terminology used within the consultation document appears to suggest that technical competence is the only form of competence that patients require from practitioners, and that clinical and cultural safety can be separated. The Council wishes to reinforce its position that the two areas of practice are interconnected and that a safe practitioner incorporates both cultural and clinical safe practice into the care provided to the patient or to the management of body tissue and samples. This includes actively considering addressing existing inequities in service provision for groups such as Māori, Pacific and disabled peoples.

19. Regulators consider matters and need to ensure that their decisions are proportionate, considerate, targeted, transparent accountable and agile[5]. Taking these principles into

[1] https://www.hdc.org.nz/decisions/search-decisions/2025/19hdc02222/)
[2] NHS-RHO-Report-Cost-of-Racism-March-2025.pdf
[3] hdc-annual-report-2024.pdf
[4] Health literacy, equity, cultural safety and competence | Te Tāhū Hauora Health Quality & Safety Commission.
[5] Right-touch regulation | PSA

account and utilising a risk-based approach to regulation, regulators do consider matters that relate to competition and access within their (limited) sphere of influence.

20. Regulators take the view that patient safety is paramount and how this is achieved is through having people with the required knowledge and skills provide appropriate care. While regulators may consider the needs of the clinical environment to have a certain number of practitioners of a certain skill set provide care, they have no direct role with regards to the demand requirements of employers. Suggesting that regulators would lower standards so that more practitioners could potentially be registered, and ultimately a gap on a roster could be filled, is contrary to public safety and would place either the patient at risk of harm, the practitioner at risk of complaint or other practitioners at risk of professional harm due to a lack of competence of their colleague. Regulators are aware of the impact of poor staffing on practitioners and the consequences of burnout. However, their influence in the employment environment is limited.

21. Decision making should have the patient at its centre. This means ensuring that decisions are adequately balancing the proportion of risk to the regulatory burden imposed. The Council accepts that it is important to regularly consider whether the framework in place is fit for purpose and reflects the needs of a modern health system. This consideration could form part of the mandated responsible authority performance review which the Council believes could have a more targeted approach.

Streamlined Regulation

22. Regardless of the model that is employed to regulate health professionals there is always the need to ensure that the regulation of a specific group manages the risk that the profession poses to the public. How the administration of this occurs can be considered, noting that amalgamation itself will have costs that would need to be borne by either the government or the professions. While examples are provided in the consultation document about the number of regulators, it is important to remember that where there is only one regulator (such as Ahpra in Australia), there may be multiple professions with their own boards that are serviced through the regulator.

23. Within the current New Zealand regulation environment there are already models that demonstrate a more streamlined approach. The Medical Sciences Secretariat (MSS) was established to provide administrative and regulatory services for two distinct responsible authorities.

24. In the MSS model processes are essentially the same for both responsible authorities. Staff at all levels and in all departments flex between the work for the different responsible authority. For example, the same registration staff member can manage work for both the Council and the Medical Radiation Technologists Board within the same working day. Project work occurs concurrently for both responsible authorities and the Registrar and CE work across all portfolios. The information management and financial infrastructure and ways of working within the MSS supports this agility and can be developed further to support new professions.

25. Further to this, the Medical Sciences Council is a multi-profession regulator. This means that the Council is responsible for the regulation of two totally distinct professions. While ensuring that standards and policy are reflective of the distinct professions, knowledge gained, and process improvement can be shared.

26. The Council is also aware that there are other models that exist utilising service level agreements for the provision of services.

27. The Council is opposed to blanket amalgamation as it has concerns that the smaller professions have the potential to be overshadowed by the voices of the larger groups. The Council also advises that all responsible authorities have the same requirements under the Act and, while the financial burden does impact smaller authorities, they do have the ability to be more agile and responsive due to the closer relationships that operate between operations and governance.

28. If it was deemed necessary to amalgamate, the Council recommends the use of technical groupings of professionals for example, 'scientific' which would include the science professions, anaesthetic technicians, medical imaging and radiation therapy. If consideration was given to other non-regulated professions, then cardiac perfusionists and medical physicists could also be included within this grouping.

29. If amalgamation of some regulators were to occur, then timing and consideration needs to be given to minimise interruptions in service and other unintended outcomes within the already stretched health sector. Impact analysis must be undertaken to understand more if groupings will be effective and that any gains can be adequately identified.

30. If there is consideration around the establishment of an overarching board as another example, then consideration also needs to be given to how regulatory functions will be performed. For example, Section 118 of the Act describes the functions of each responsible authority. If a number of responsible authorities were merged with one multi-profession board, then obvious flow on effects would relate to how the professions represented by that board would comply with their requirements.

31. While administratively there could be long term gains from combining finance and people & culture departments, it could be that the same number of professional staff are still required to ensure compliance with regulatory requirements. This is not to say that the development of an overarching board could not occur, but that serious consideration needs to be given, and robust analysis undertaken, before a decision is made.

Right sized regulation

32. There is general agreement that the regulation of practitioners needs to be proportionate to the risk posed to the public by the professionals. Regulators understand that the process of registration can be challenging for some people who wish to practise in a new jurisdiction; there is an assumption that registration in one country means you will be entitled to registration in any other, regardless of the

differences in practice. Protecting the public is about more than demonstration of clinical and technical competence but also includes consideration of character as well as personal health circumstances. Further, that while some technical aspects of practice may be the same, roles and responsibilities within the practice environment may be very different.

33. When considering applications for registration evidence shows from the Council's annual report (2024) that for the Medical Science Council between 85-99% of all applicants for registration are successful. Processing times vary between local and international applicants.

34. The Council agrees that there could be options for other lower risk non-regulated professions to have a formal process for self-regulation as described within the consultation document. Some of the processes that are described already occur with the current regulated workforce for example, credentialling and certification. Within the current context these are seen as further enhancements or safety measures that are employed within practice. Often tasks that are associated with these processes are above those expected of entry level practitioners or can be specific to a context or circumstance.

35. As the landscape within health changes, then the needs and requirement for practice and what constitutes competent practice also needs to be reviewed to ensure that they are robust and informed by evidence. While within the consultation document there is reference to clinical practice hours requirements, it is important to consider the different roles and responsibilities of practitioners within the New Zealand and other contexts to ensure that the minimum standard of competence is met for practice here. Arbitrary comparison between jurisdictions may not reflect the level of responsibility that is expected of practitioners entering the register.

36. The Council acknowledges that the shortage of practitioners is a key factor in poor health outcomes within New Zealand and that consideration needs to be given to how care can be provided. The Council is also mindful that the workforce issues are international and not just New Zealand specific. The Council endorses statements by the Professional Standards Authority (2025) that articulate that there is a need for regulators to be agile and keep pace with changes and, further, that regulators have an important role in regulating for new risk and helping to reduce inequalities (PSA, 2025, p.8). The Council believes that this is embedded within the current HPCA Act through section 118 that clearly articulates its roles and responsibilities however, this could be strengthened to provide further direction to regulators.

37. There should be a process for review of regulator decisions so that decision making is transparent. An occupations tribunal would be welcome as this would mean that there is a place where matters can be reviewed outside of the court system. However, the defined purpose to review decisions from practitioners and countries with equivalent or higher standards does not make sense, noting that New Zealand has internationally high standards and that if processes for registration assessment are robust these practitioners would most likely be registered. Further, the cost, efficiency and establishment of any tribunal would need to be given serious consideration.

38. The Council sees streamlining of processes with regard to return to practice and other assessments as part of the regular review that regulators should undertake. Again, as highlighted above, changing context and requirements mean that there is a need for regulators to measure the practice of the clinician against the associated level of risk and public safety on a more regular basis. This is particularly important in female dominated professions with evolving work/life balance expectations. Requirements like this could be more formalised within the responsible authority performance review processes where regulators would need to demonstrate how they review these requirements to ensure they are fit for purpose.

Future proofed regulation

39. Occupational regulatory decisions are focussed on the individual practitioner not on provision of service. Regulators are aware of the impact of their potential decision on the workforce pipeline. Regulators exist to protect the health and safety of members of the public by ensuring that practitioners are competent and fit to practise. The patient's needs, a safe practitioner to provide care, is at the centre of this decision making. The Councils work programme supports future workforce development and aligns with the Government Policy Statement on Health 2024–2027 | Ministry of Health NZ and the Health Workforce Plan 2023/24 – Health New Zealand | Te Whatu Ora

40. Regulators and the stewards of the health system need to consider new and enhanced roles that can support the delivery of modern health care practice. A recent example of this is the change in the scope of practice of anaesthetic technicians which has seen some tasks once considered expanded practice now become part of the general scope. Reviewing and adapting the scope of practice means that this has enabled practitioners with appropriate education to work in non-traditional settings, thereby supporting the safe and efficient provision of care to patients through an inter-professional and collaborative approach.

41. Change and identification of new professions or roles can be achieved through collaboration between the regulators, the providers and also professional associations. The same exists for review of qualifications. The Council recommends that responsible authorities can demonstrate how this is achieved, and that consideration could be given to including this as part of the responsible authority review process.

42. The Government already has a number of powers within the HPCA Act that are proposed in the consultation. For example, the Minister has the power to audit responsible authorities and further, as mentioned, performance reviews occur on a five yearly cycle. The Council would welcome the provision of a letter of expectation; however, it is not supportive of having the government issue instructions to the regulators about operational matters and is concerned about the level of interference that could occur. Review of the Council can be achieved through the use of the performance review and believes that this should be an effective means of demonstrating its work. It would also see value in a joint Ministry responsible authority and employer strategic forum that identifies issues of relevance and believes this could

assist in identification of targeted initiatives to address matters related to the regulation of professions.

43. From a patient perspective the Council supports the development of a shared register that could support patient access to information, however the development of a shared IT platform would have a considerable cost, which ultimately would need to be paid for by the practitioner or the government. Notwithstanding the need for consideration be given to a patient facing resource, as part of future proofing, the Medical Sciences Secretariat has ensured that its new database has the ability to add new professions or regulators onto it.

44. The Council is supportive of a multi-disciplinary approach to practice and collaboration, and supports future proofed regulation, and enables and actively promotes interprofessional and collaborative patient centred care. The evidence-based benefits of pre- and post-registration interprofessional education - IPE (eg leads to improved collaborative care in practice) and the benefits of interprofessional collaboration itself feature strongly in our risk assessment processes, especially the benefit of interprofessional education in pre-registration programmes of education. The Chief Executive is part of the National Centre for Interprofessional Education and Collaborative Practice - AUT and is working with other responsible authorities to implement a statement of intent on interprofessional collaborative practice and education.

45. The responsible authorities have established fora and channels for communication where matters of common interest are discussed. Staff members within the Medical Sciences Secretariat are contacted by their peers for advice and guidance around regulatory matters.

46. The government, via the Minister of Health, already has the ability to appoint members to regulatory authorities to ensure that decisions made are with the patients' best interests in mind. The functions of the Act require these members to ensure the health and safety of the public by ensuring that practitioners are competent and fit to practise. To this end, and through the implementation of standards that are reviewed regularly, the members of the regulatory boards ensure that the workforce is responsive to the needs of patients. However, as stated above, regulators and the stewards of the health system in collaboration with the professional associations need to consider safe innovation and availability of service.

47. The Council thanks you for the opportunity to provide feedback on the consultation. We look forward to working with you as matters progress and would welcome the opportunity to discuss this with you.