New Zealand's Health Practitioners Competence Assurance Act

A missed opportunity for improvements to medical practice

MEDICAL PRACTITIONERS in New Zealand are to be regulated by a new piece of legislation — the Health Practitioners Competence Assurance (HPCA) Act. The stated purpose of the Act — "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" — while laudable, is ambitious and conceptually flawed.

The initial aims of the Bill, as proposed by the Minister of Health, were widely supported. It was to be an omnibus piece of legislation designed to bring 16 health practitioner groups (including dentists, nurses, chiropractors, midwives, pharmacists, psychologists and other allied health practitioners), regulated by 11 statutes, into line with the registration, competency and discipline provisions of the NZ Medical Practitioners Act 1995. The Medical Practitioners Act was modern, effective and cognisant of societal changes (such as the need for openness by having disciplinary hearings in public). There had been wide consultation and debate associated with its development, and it had the support of major medical professional groups, both in the development phase and in practice.

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During a long gestation period, however, the initial concept of the HPCA Bill became lost under the onslaught of multiple competing agendas. The resulting legislation is complicated and undermines professional functioning. Its effect may be exactly the opposite of its intention — to make the provision of health services safer and of higher quality. From initial tentative support, the leading medical professional organisation in New Zealand — the New Zealand Medical Association (NZMA) — along with the union representing senior hospital doctors (the Association of Salaried Medical Specialists), and the major medical colleges of surgery and general practice, ended up opposing the legislation in favour of retaining regulation under the Medical Practitioners Act. We were unsuccessful.

So how did these changes come about? And how did the New Zealand Government come to pass a law that was actively opposed by organisations representing many of the people who would be bound by it?

First of all, there was no doubting that much of the legislation covering other health practitioners was outdated and in need of modernising (eg, laws regulating occupational therapists and physiotherapists dated back to 1949). The advocacy of many of these other health practitioner groups, while publicly supportive of the concerns of the medical profession, was in the end more muted because of issues with their existing outdated legislation.

Secondly, Ministry of Health consultation on the Bill was primarily with the statutory bodies that would be administering the new legislation (such as the Medical Council of New Zealand). These bodies do not and cannot represent practitioners, as their statutory role is to regulate them. Professional medical organisations received little consultation. Such consultation that did occur was late and completely inadequate, and despite strong and detailed responses, concerns raised were largely dismissed.

Thirdly, there is a political perception that more political and external controls on the professions are what society wants. This runs counter to repeated polls that place professions such as medicine and nursing high in the public trust, with politicians scoring poorly in this regard. It also ignores the growing body of international opinion that competence, quality and safety are better assured through models structured on professionalism rather than state control.[1]

Consequently, as the legislation developed, it moved substantially away from the concepts and clarity of processes of the Medical Practitioners Act on which it was supposed to be based.

The NZMA believes the new Act is a missed opportunity for improvements to medical practice and offers no assurance of further benefits to patients. It will increase political influence and bureaucratic involvement in the practice of medicine, with a consequent decrease in professional self-regulation, which has been at the core of the development of safe healthcare for New Zealanders.[2]

As Onora O'Neill, Cambridge Professor of Philosophy, as well as teacher, bioethicist and politician, said in her 2002 Reith lectures:[3]

> Plants don't flourish when we pull them up too often to check how their roots are growing: political institutional and professional life too may not go well if we constantly uproot them to demonstrate that everything is transparent and trustworthy.
>
> Perhaps the culture of accountability that we are relentlessly building for ourselves actually damages trust rather than supporting it.

The Act, as passed (among other things):

- provides for additional Ministerial powers;
- introduces scopes of practice for all health practitioners;
- introduces restricted activities; and
- mandates regulatory authorities to set standards of ethical conduct.

Along with cumbersome bureaucratic requirements, the HPCA Act significantly increases political control over doctors. The Minister of Health now has powers to resolve disputes over scopes of practice, to designate restricted activities, and to appoint all the members of regulatory authorities (eg, the Medical Council, which currently has four members elected by the profession). The Minister may also allow new health practitioner groups to become regulated under the Act.

The introduction of legislation-based scopes of practice is an unproven concept and has the potential to bring about substantial change to the practice of medicine, particularly if scopes of practice are narrow and, as the NZMA fears, become highly codified and prescriptive. Practitioners will be limited in the activities they can practise by the details of their scope of practice, irrespective of possible wider competencies, and disciplined if they step outside that scope. The Minister of Health now has powers to resolve disputes between authorities over scopes of practice, which should be entirely a matter for the professions and not subject to bureaucratic influence or political decisions. Consequent changes in other statutes, the decisions of future authorities appointed by the Minister of Health, determinations by case law, and inclusion in employment contracts, with time, are likely to make scopes of practice more restrictive and task oriented.

Restricted activities, which may be undertaken only by specified practitioners or disciplines, are another new and untested legislative concept, with uncertain outcomes. As the process is defined in the Act, the declaration of restricted activities may potentially be responsive less to professional and patient safety realities than to political pragmatism.

Another major concern is the mandating of statutory regulatory authorities to set standards of ethical conduct. Effectively, this could mean people appointed by the government setting ethical standards for the profession. For the safety of patients, the independence of medical ethics must be protected from political agendas.

William Sullivan, a prominent North American sociologist said:

> Neither economic incentives nor technology nor administrative control has proved an effective surrogate for the commitment to integrity evoked in the ideal of professionalism.[4]

Health legislation can actively promote professionalism — or it can discourage it. The NZMA believes that the HPCA Act is a backward step for the promotion of professionalism in medicine. We are establishing a monitoring process to assess the effects of the Act on both doctors and their patients so that we will be prepared for the planned review in 2006.[2]

Tricia A Briscoe

Chairman, New Zealand Medical Association, Wellington, NZ

nzma@nzma.org.nz

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