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A Joint Submission from a group of organisations representing the health professions on the HWNZ proposal for a shared secretariat and office function for all health-related regulatory authorities together with a reduction in the number of regulatory authority board members

Introduction

This submission represents the collective views of a number of key health professional organisations. Together these organisations represent some 50,000+ health practitioners. Each organisation will submit independently. This submission however forms an agreed general position of these organisations as indicated by the signatories below.

We wish to be invited to be part of the discussion and involved in the process. This is because our members will be directly affected by the proposed changes, that we have a pragmatic approach to change and offer these comments as advice in the expectation that they will inform the debate and improve the proposal being developed.

We also ask for a formal response and engagement in the process as many of the staff involved in this submission have been intimately involved with the HPCA Act since its inception and have a wealth of knowledge to contribute to the evolutionary process.

We agree efficiencies need to be achieved and that voluntary processes to date have not achieved the savings or efficiencies expected or demanded in the current economic environment.

We wish to draw your attention to legal precedent and the requirements around consultation processes and note that, in our view, this process falls well short of the expected standard.

In particular, the representatives are concerned to note that access to this important discussion document appears to have been constrained by both distribution process and length of time open for submission. We also wish to note that the timeframe for submission on such a significant proposal is short, given some organisations meet infrequently or cyclically outside the submission timeframe.

We also note that some signatories have been affected in their capacity to respond by the Christchurch earthquake. Their members have also been directly affected in terms of responding in a timely fashion to APC renewals issued by the regulator. This point is relevant in regards to this proposal, future planning and risk management. For one secretariat or even two- to be responsible for up to twenty professions in one of the more quake prone cities of the country – we ask what strategies have been put in place or costed to deal with major interruptions in the issuing of all APCs from one physical site? What back-up systems are proposed for IT storage should the server fail or professional APC records and personal information be lost? One only needs to look at the cancellation of the national census managed out of one distribution point - Statistics NZ Christchurch offices - to see the negative effect on the country and the high cost of restoring massive data processes. The risks to the health sector of having potentially all health workforce information and regulatory data stored in one site have not been explored in this paper or identified even as a risk.

We appreciate the need for urgency of the turnaround time on the paper given the implementation timeframe proposed, yearend 2011, but consider this could be addressed in a number of ways, e.g. focus groups, improved dissemination at one point in time to a wider audience, a one day forum seeking informed advice on options to address effectiveness and efficiency concerns of RAs and/or professions, etc.

General Comments

We note the proposal shifts the responsibility for the collection of health workforce data to the responsible authorities. This would be a new function and we question whether it should be a core function of the RAs? The HPCA Act sets out the functions of the RAs in section 114 alongside Section 3 - the intent of the Act - which is to protect the health and safety of the public. We doubt that collecting workforce data and being the primary repository of that health workforce data should be a key function of the RAs. This in our view, is a core government responsibility and we doubt that funding will shift in line with the demand for better reporting on workforce or improved access to collated information.

We also question the legality of collecting private personal information often supplied voluntarily, e.g. hours of work, limitations imposed on practising certificates, for the purposes of issuing APCs and restrictions on practice which may then be used for a purpose other than that originally intended. Indeed there may be a potential conflict in the sharing

of that information for statistical or workforce planning purposes. We suggest that the Privacy Commissioner be consulted on this aspect of the proposal.

The document proposes a streamlined one secretariat proposal with ostensibly a reduction in back room office staffing from 165 to 100 personnel. We agree that efficiencies could be found through improved collaboration and sharing. The health professions recommended in the 2009 review that there was room for improvements in economies of scale and efficiencies through on-line processes, shared functions, a more systematic approach to collecting like information, etc. But we are concerned that the estimate of reduced staffing does not take sufficient account of the volume of work or range of activities undertaken by the RAs and does not appear well supported by a scoping exercise or appraisal of functions or performance across the RAs.

The number/volume of APCs overall to be issued will not necessarily reduce unless a change to the annual cycle is implemented (i.e. a 3 yearly cycle for good behaviour/clean record), or a simpler one-size fits all APC is developed. In which case where does the public safety threshold -sit- at the high end or low end? Recent Australian experience demonstrates that changes to national registration significantly impedes productivity at least in the initial phase and results in health professionals practising unlawfully without current APCs (see attached articles). We suggest further work be undertaken to justify the pace of change and that this will not adversely affect the practice of professionals. The loss of productivity due to poor transition planning and poor implementation may very likely outweigh the benefits of the proposed changes at least in the short term

We question the projected transition costs including redundancies and IT changes of $3.1 M that will be offset by savings within 3 months. Business analysis we have had undertaken suggests the appendices only allocate $60,000 for redundancies. This appears to be an underestimate of transition costs even taking staff attrition into account. There is a lack of account for holiday pay accrued at 8% especially given some staff in the RAs have worked for them for many years, there is no allocation for legal costs relating to personal grievance provisions, insufficient allowance for exit of lease provisions entered into by the RAs for premises, photocopiers, waste disposal or storage leases, etc., and in our view given the diversity of IT systems within the RAs a significant underestimate of the cost of transitioning to a new (and, as yet undeveloped) IT system that can provide for a streamlined one-secretariat back-office service.

We also cannot find in the discussion document any mention of treatment of residual assets of the RAs which was problematic at the time of the HPCA 2003 implementation in terms of asset split between the Nursing and (new) Midwifery Councils. This background should have informed the paper in terms of risk management. Given the RBS and MSS secretariats have provided services to more than one regulatory board the question of residual assets and what will happen to the divestment of these should further consolidation be imposed must be addressed in the paper. The two aforementioned models illustrate a collective private

sector approach to management of regulation of the professions but funded through the public purse, and in our view, these issues should have been given more solid attention within the discussion paper. There is a complete silence of information on these points.

Board representation reduced members from 140-to 116 - Fifth and preferred option

We note the paper generally recommends a reduction on Board numbers to 7 albeit for medicine and dentistry to 9. This is inadequately explained other than we assume it is to do with the number and complexity of scopes of practice in these professions. We appreciate the need for synergies where these can be achieved and consistency of approach across the RAs including the best skills/knowledge for RAs appointments. However, we are concerned at the risk of loss of technical knowledge if the board member numbers are reduced without first identifying the functions to be retained or size of workload to be directed at the same time staff reductions are introduced. The Act is explicit in the proportion (and numbers) of lay representatives and we acknowledge the value these members contribute to the process. However we query whether it is possible to provide for both adequate lay representation and specific technical knowledge being maintained at a sustainable level on a Board of 7? We also query how the difference in numbers was arrived at for two professions versus the other 14 groups under the Act? The paper is brief on detail and reasoning.

We support a move to an improved and streamlined approach to regulation but believe a range of solutions could be promulgated and developed with more rationale to support them if the right questions were asked of the right people and right organisations. HWNZ appears poorly informed of prior debates and recommendations form the 2009 review. While this occurred under a Labour led Government useful information could be gleaned from the submissions at the time.

We note that there is lack of well thought out discussion in the paper of the share of costs of disciplinary cases except a suggestion that the RAs with the most disciplinary cases be consolidated – a naughty basket of regulators with higher numbers of naughty practising professionals. Doesn't sound a winner to us and we are concerned at the lack of analysis that currently the RAs pay proportionately for HPDT cases, therefore the model does not sit well with the current existing arrangement between RAs. Maybe positive incentivised structures would work better.

Conclusion

As noted above the submitters in turn will forward their own detailed submissions. This submission covers points of common interest for us all and we would appreciate feedback and further engagement. For contact please email: nzsa@anaesthesia.org.nz

Parties to this submission:

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