New Zealand
PSYCHOLOGISTS BOARD
Te Poari Kaimātai Hinengaro
o Aotearoa

SUBMISSION IN RESPONSE TO

THE MINISTRY OF HEALTH'S

2012 REVIEW OF THE HEALTH PRACTITIONERS COMPETENCE ASSURANCE ACT 2003: A DISCUSSION DOCUMENT.

AS SUBMITTED 23/10/12

Introduction and context

Our thanks to the Ministry for inviting our submission on the 2012 review of the Health Practitioners Competence Assurance Act 2003 (the **Act**).

The principal purpose of this Act is to protect the health and safety of members of the public … *(s 3, HPCA Act)*

This clear and useful statement of the principal purpose of the Act has been the touchstone for Regulatory Authorities for the past eight years. Anything and everything we do is referenced back to it, and the Psychologists Board believe that this is as it should be. We also believe that the benefits of this clarity could be extended by including in the Act brief statements in regard to its other (lower order) purposes and some core guiding principles. This would serve to sharpen and facilitate each Authority's efforts to apply the "right touch" and thereby strike a proper balance between public protection, cost, and other important demands (such as facilitating the development of a flexible workforce).

The Board also agree that the Regulatory Authorities have (and should retain) an independent role in keeping the public safe. This independence, coupled with each Authority's close connection with their practitioners, is a cornerstone of effective regulation.

In preparing our submission the Psychologists Board (the **Board**) has considered the principles that it believes should be relied upon in conducting the review. These include;

- That any fundamental change to legislation that is apparently working well must be carefully considered and must clearly and reasonably promise benefits that outweigh any risks that accompany the change. The ultimate test must be whether or not any proposed changes will, on balance, maintain or improve upon the performance of the current regulatory system and upon the current protection of the public.[1]
- That the Regulatory Authorities (**RAs**) covered by the Act must be readily accessible to the public, must be demonstrably responsive to the needs of the public, and must work and communicate based on a foundation of competence and expert knowledge of each profession.
- That, in order to assure adherence to Administrative Law (and thereby minimise the risk of error and costly judicial reviews and/or appeals), regulation of a health profession requires clear and authoritative governance and appropriate delegation of authority to a suitably resourced operational structure.
- That, as psychologists are employed across a span of sectors and occupational settings (and not just within the typical health context), the Psychologists Board must take a particularly flexible and collaborative approach to ensure that the current high levels of voluntary compliance are maintained.
- That regulation of health professions requires a deliberate, well-constructed balance of administrative and profession-specific expertise.
- That RAs should strive to work with practitioners and to support the self-regulation that already exists within the professions.

[1] Protection of the public should be understood to include ensuring high quality and effective services that achieve the desired results.

- That collaborative, voluntary approaches to improving regulation are preferred to a heavy hand, as they facilitate practitioner engagement and compliance.

Purpose of the review

The Ministry has established this review to examine the policy principles underpinning the HPCA Act and their impact on the public, health care service providers, and health professionals to determine if these principles continue to support the requirements of a rapidly changing health sector.

While we agree that the Act must balance competing priorities in order to fulfil its intended functions, it has (and must maintain) as its clear and primary purpose the protection of the public. It is our submission that this purpose must remain as the core of the Act, and must be the touchstone against which any and all proposed changes are considered. That is, while changes to the Act to support workforce flexibility, cost savings, and value-for-money are desirable, they should only be implemented where there is credible evidence that they will not undermine the Act's principal purpose. We note that this is in accordance with the noted international trend of strengthening consumer protection.

[*Aside: We understand that the proposed changes arising from the 2007 - 2009 review of the Act are still being progressed through the legislative process. On that basis we have not included any detailed reference to them in this submission*.]

Future focus: A health occupational regulatory framework that supports workforce flexibility, working in multidisciplinary teams and clinically networked environments

Overview:

Psychologists make diverse contributions to health and wellbeing throughout society, including areas which are not specifically identified as in the health arena (e.g., in the fields of occupational, community, and educational psychology).[2] While some have expressed unease at being classified as a "Health Practitioner" under the HPCA Act, most seem to appreciate the flexibility the HPCA Act provides. In 2003 the Board decided to define very few scopes of practice, to describe them very broadly, and to prescribe common core competencies that underpin them all. By so doing we intended that the scopes would reflect and support the long-standing pattern of psychologists shifting or expanding into new areas of practice. This approach was entirely possible under the Act in its current form.

Looking forward, we believe that part of an RA's role is to ensure:

- that the accreditation standards they establish keep abreast (and even ahead) of future-oriented health care delivery,
- that any standards imposed (including registration qualifications and continuing competence requirements) are only those truly necessary to protect the public,

[2] For a more detailed analysis of psychologists' contributions see Michelle Levy's (2005) *Overview of Actual and Potential Contributions of the Psychology Workforce to Health objectives: Innovations and Future Directions. Report Submitted to the New Zealand Psychologists Board Workforce Working Party.*

- that, in support of a flexible and collaborative health workforce, competency requirements include a strong emphasis on communication and collaboration with other disciplines, and
- that individual practitioners be supported to maintain and grow their competence in reference to an evolving health care system. (A good example of this is the project currently underway to explore the granting of limited prescribing rights to some psychologists.)

While we believe the Act in its current form already supports these requirements, the inclusion of explicit principles[3] to guide the implementation of the Act could facilitate the RAs' efforts to make consistent, balanced, and well-grounded decisions.

Response to discussion document questions:

1. *We want to achieve the best outcomes for patients through integrated care, and so health professional regulation needs to keep pace with how integration improves care and service models. How can the HPCA Act improve this?*
    - It should first be noted that integrated care is achievable under the Act in its current form, and that many practitioners (including psychologists) already routinely work as part of well integrated multi-disciplinary teams. In fact, we are unaware of any evidence that suggests the Act or the RAs in implementing the Act are actually blocking or slowing the (further) development of integrated care approaches.
    - We believe that clear and broad definitions of scopes (underpinned with well-defined, generic and profession specific competencies and backed up with robust accountability mechanisms) are needed to support an integrated, flexible workforce.
    - While RAs can consider (as one aspect of their investigations) how system issues may have impacted on an individual practitioner's competence and/or conduct, it is the Health and Disability Commissioner (**HDC**) who has the expertise and mandate to specifically investigate concerns re systems, organisations, and multi-disciplinary teams. While there is certainly a role for RAs to assist the HDC in such matters, we believe it is appropriate that the overall responsibility for them remain with the (independent) HDC.

2. *How can the HPCA Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?*
    - The current Act is non-prescriptive in regard to the establishment of accreditation standards and the level of detail to be included in gazetted scopes of practice. As evidenced by the Board's practice since 2004, broad scopes[4] can be established that adequately describe the work of the profession but that are also flexible enough to not unnecessarily restrict the range of a practitioner's practice. The practitioner's range of practice is subsequently constrained primarily by ethical and competence concerns, not by the breadth of their scope of practice. If there is a problem with how some RAs are currently defining and interpreting scopes then perhaps the Regulations

[3] These principles could, for example, be a distilled version of COAG's Principles for Best Practice Regulation (2007).

[4] The Board has gazetted a very broad "Psychologist" scope that all practitioners hold (alongside any vocational scope they also hold) once fully registered. Incidentally, the Psychologist scope overlaps to a significant degree with the main scope gazetted in 2008 by the Psychotherapy Board.

Review Committee (**RRC**) could be asked to review any new scopes (or proposed changes) prior to gazettal. Such a review should of course be against a set of explicit principles promulgated to guide the implementation of the Act, and could also reference the principles for developing new scopes suggested in the 2007 - 2009 review of the Act.

- Finally, continuing competence requirements can be used to ensure that individual practitioners continue to 'up-skill' to meet emerging challenges in the health system and in society generally. Ensuring that practitioners maintain competence through on-going professional development is implicitly covered by various functions under s118, but could be included more explicitly as a function in its own right.

3. *How can the HPCA Act promote education and training that has a wider focus, such as effective ways of working in teams, improved communication skills and support for consumers' self-management?*
    - As noted above, the Psychologists Board has found that this is already quite possible under the current Act. By tying our accreditation standards to broad scopes and to practical and generic core competencies, and by including 1500 hours of practical training (internship placement) in our registration qualifications, we are confident that new graduates are able to integrate quickly and productively into a team setting.
    - We note that excellent communication skills and supporting our clients' self-efficacy have long been core to psychology practice.

4. *Is there scope for the HPCA Act to better address the standardisation of codes of conduct, ethics and common learning across health professions?*
    - Codes of Ethics by their very nature tend to have a high degree of overlap. It is nevertheless important that they remain profession specific to ensure that practitioners identify with and "own" them, thereby promoting adherence.
    - Codes of conduct, on the other hand, are usually designed to be sector, employer, profession, or even role specific. This is understandable as, while it can be useful to have an over-arching, common code (e.g., the HDC Code) that all practitioners in a sector uphold, there is also value in having focussed, brief, and clear rules of conduct that each profession identifies with. One can easily imagine that the sorts of ethical and/or conduct issues that arise for laboratory scientists are likely to be markedly different than those that commonly arise for psychologists. And one can just as easily imagine that a practitioner could begin to question the relevance and value of a code that covers a lot of territory that is completely foreign to them. In summary, it should be "both, and", not "either, or".
    - While we believe there is already a great deal of common learning amongst the professions, there is also room for improvement. For example, cultural competence is of great significance for all occupations that require a focus on effective engagement to achieve the desired outcomes. The development of competencies to work with the most vulnerable populations (which are currently Māori and Pacific) could and should be strengthened, perhaps by specific mention in the guiding principles we proposed earlier in this submission.

5. *Do we have the right balance between broad scopes of practice and providing sufficient information to inform people about what they can expect from a health practitioner?*
    - The Act as it stands does not give any guidance in regard to how a scope should be constructed, but it is entirely possible to achieve the right balance within its framework. As noted above, the inclusion of guiding principles in the Act could assist.
    - S 118(l) notes that one function of an RA is to promote public awareness of the responsibilities of the Authority. We believe that much more could and should be done to educate members of the public about regulation (including scopes of practice). (Employers, contractors, and health insurers also could benefit from a better understanding of scopes.)
    - It is also important to remember, however, that scopes written for a legal or regulatory purpose may not always be easily interpreted by members of the public. RAs could assist by also publishing plain language descriptions of what their practitioners do.

6. *Could/should RAs have a mandated role in health professionals' pastoral care? If so, how can they carry this out?*
    - While RAs can (and should) be supportive and caring in their dealings with practitioners, they cannot be 'the' supporter and carer. That is to say they can assist, but they cannot be both regulator and compassionate friend. We advise great caution in regard to the inherent conflict in these roles.
    - RAs already can and do work closely with employers, colleagues, and supervisors to ensure that practitioners undergoing fitness, competence, and/or conduct processes are appropriately supported.
    - RAs could also endorse other allied organisations (e.g., a collegial body) to provide support to a practitioner.
    - RAs can also promote, recommend, or even mandate supervision and mentoring which can be very helpful to practitioners throughout their careers.
    - So while the Act could require that RAs advise practitioners as to how to access support, the RAs should not themselves be mandated to provide that support.

Consumer focus: Operation of the HPCA Act in a way that is accessible and transparent for consumers

Overview:

The Board strongly supports the principles of transparency and open access to information, and our processes under the current Act reflect this. We note, however, that such access must be balanced with the privacy, natural justice, and other legal rights involved in any particular situation.

In regard to the routine governance and operational functioning of the RAs, we believe that the public have every right to know how, why, and on what evidence decisions that may affect them are made.[5] Again, our practice under the current Act already reflects this, so we do not believe that any changes are needed to allow it. We also do not believe that the RAs

[5] RAs should, for example, publish the evidence they have relied upon in prescribing any standard (especially where that standard may have significant cost implications).

should be made subject to the Official Information Act (**OIA**) as our experience has been that the process is abused by some people, with resulting very high costs to the RA.

The Board strongly supports the need for consumers to be consulted as part of all significant decision making processes. This should, however, be as key stakeholders, not by appointing one or more them as governors (board or council members). Governors must be careful to consider the needs of all affected parties, not just one subgroup thereof. It is for this reason that the Ministry advises new appointees to the RAs that they must not see themselves as representatives of the body that nominated them. For example, while an RA's lay members bring a valuable external and independent point of view to the table, they do not "represent" the public or consumers *per se*. Consumer forums appear to have great potential as an adjunct to the more specific consultation that already occurs.

The RAs and the Ministry have, in our opinion, failed to adequately inform and educate the public about the Act. It seems likely that a majority remain unaware of the Act and what it means for them. As identified in the 2007 - 2009 review, we must all do more to inform the public about the Act through our websites, publications, and other means. It is also critical that this information be communicated in an accessible way – in Māori, Pacific and potentially Asian languages, and for people with disabilities (e.g. vision impaired). The Board are keen to work collectively with the Ministry and with the other RAs to take action on this issue.

Response to discussion document questions:

7. *Does the HPCA Act keep the public safe, involve consumers appropriately in decision-making and assist in keeping the public informed?*
    - Probably as much as any legislation can, and we believe that the Act will be even more effective once the changes proposed as a result of the 2007 - 2009 review have been incorporated.
    - Although the Board routinely involves consumers and community members in all significant decision making processes, we think the idea of community panels holds some promise for facilitating input on more generic, sector-wide matters (such as the development of common policy).
    - There is a definite need for better public education[6], but we do not see the current Act as an obstacle to that. The legislation could however be enhanced by including a description of each organisation's respective roles and responsibilities re public education.

8. *Is information from RAs readily available, particularly as it relates to practitioners and the transparency of complaints and complaint processes? If so, is this information made good use of by the public?*
    - Our experience is that this information is readily available. Our website, for example, includes very full information about our processes (including published guidelines for complainants and our full decision-making guidelines for Parts 3 & 4 of the Act). Website analytics show that the related pages are viewed on average 10 times a day.
    - The details of individual cases cannot and should not however be totally open, as this would compromise the practitioner's legal rights and could undermine rehabilitation efforts. The RAs already have online Registers that show what

[6] Specifically, education about scopes of practice and titles could be strengthened.

conditions a practitioner is subject to, and this is usually sufficient to ensure that the public are appropriately informed.

9. *Do we have the right balance of laypeople to health professionals on RA boards?*
    - Yes. We believe that the nature of the mandated work of the RAs requires that the majority of members be practitioners, with strong lay or community member presence. We have found the current formula to work well.

10. *Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?*
    - This sounds like a promising opportunity. We would caution however against the possibility of single-focused consumers or consumer groups "hijacking" such forums. It would also be crucial that any such consultation must be robust, meaningful, and demonstrably effective so as not to frustrate and alienate those who invest themselves in the process.

Safety focus: A systems perspective that balances individual accountability with team and organisational accountabilities for the management of consumer safety

Overview:
As we have noted above, it is the HDC who has the expertise and mandate to specifically investigate concerns re systems, organisations, and multi-disciplinary teams. While there is certainly a role for RAs to assist the HDC in such matters, we believe it is appropriate that the overall responsibility for them remain with the (independent) HDC.

Since 2004 the HDC has referred (either formally or informally) the vast majority of complaints (back) to the Board, and has only rarely completed a full investigation. We believe that the respective roles and responsibilities of the HDC and the RAs in addressing complaints need to be clarified. We also note that the HDC focuses on the Code of Health and Disability Support Services Consumers' Rights which covers some, but definitely not all, of the same territory as our Code of Ethics and Best Practice Guidelines.

While employers can and should deal with conduct and complaint matters in the first instance, it must be acknowledged that in so doing they would have conflicting roles and interests. We often work alongside employers to support their first line efforts, but we always make it clear that we may need to escalate any given matter under the Act if (for example) it appears that public safety remains at risk. This approach greatly reduces duplication, complexity, and cost, and by all accounts seems to work well. Importantly, it also provides assurance to the public that there is an external, independent body involved who can and ultimately will hold the individual practitioner accountable for competent, safe practice.

Response to discussion document questions:
11. *Do we currently make the best use of legislation to keep the public safe from harm when accessing health and disability services?*
    - We are confident that, after six years of experience and continuous quality improvement, the HPCA Act is being well used by the Board.

- As noted in the 2007 - 2009 review, we believe that there is a clear need for the Ministry to more consistently and assertively enforce sections 7 & 8 of the Act. The public can only rely on the Act's protective mechanisms where they can be sure that the practitioner they are working with is actually accountable under the Act. Currently there are far too many non-registered practitioners taking advantage of the lack of enforcement to mislead the public and thereby put people at risk. Adequate enforcement would also include robust public education about the Act (and especially about ss 7 & 8).
- As noted above, the respective roles and responsibilities of the HDC and the RAs in addressing complaints need to be clarified.

12. Can we make better use of other legislation or employer-based risk management systems and reduce reliance on statutory regulation?

- We are concerned that, while employers can manage complaint and conduct matters in the first instance, they will always have competing interests.
- The Act could spell out (perhaps in a set of guiding principles) that concerns should normally be addressed in a progressive fashion, starting locally with the least intrusive and most collaborative approaches and only escalating where clearly necessary. This approach is consistent with regulatory developments in other countries (e.g., the United Kingdom).
- RAs should, however, always have the core, overall responsibility for practitioners' conduct and competence, beyond any single incident that may be addressed by other bodies and/or via other legislation.
- It is also important to note that, like a number of other RAs, the Psychologists Board's Register includes a large number (possibly even a majority) of practitioners who work in solo or small group private practices. An analysis of past complaints shows that the great majority were made against psychologists who work in private practice. This could mean that employers are successfully resolving complaints made directly to them, or perhaps that larger (employment) systems provide other mechanisms that support good practice and/or reduce the likelihood of poor practice. But in any case, with so many practitioners working in private practice, we cannot look to employers for a full solution.

13. What more needs to be done to address gaps or overlaps in legislation that could improve the overall quality and safety of services?

- The respective roles and responsibilities of the HDC and the RAs in addressing complaints need to be clarified.
- The HPCA Act currently barely mentions the need for cultural competence. Given New Zealand's unique make up and the over representation of certain cultures (especially Māori and Pacific) in the client base of many health professions, and given what we know about the centrality of cultural competence in engaging clients in health services and preventative care, we believe that the Act should be strengthened in this regard.

14. Is the HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?

- As highlighted in the 2007 - 2009 review, the language in the Act is somewhat unclear in regard to risk. As noted in the current consultation document, there is no definition of harm or serious harm in the Act and so the RAs have had to

develop their own working definitions relying, for example, on the principle of minimum interference. We believe that the Act could be strengthened by including in it a list of core guiding principles which would serve to facilitate each Authority's efforts to apply the "right touch" and thereby achieve an appropriate, sustainable balance between public protection, cost, and other important demands.

- We have noticed that complainants often expect us to deal quite harshly with practitioners who have committed even minor offences. Again, it would be useful to have some guiding principles in the Act (to which RAs and members of the public could refer) to define and explain the rationale for the threshold at which more formal, intrusive, and expensive engagement is required.
- In the absence of clear risk definitions in the Act, the RAs have developed policies, guidelines, and interpretations to fill the gap. We understand that most of the RAs have worked collaboratively on this effort, and as a result we now all have core definitions that are very similar. Case law has also built up around these definitions.

15. Do you have any suggestions how those in sole practice can better manage risks related to their clinical practice?

- A number of professions, including psychology, have developed very strong cultures of supervision and continuing competence/professional development. What little research there is in the field suggests that we should continue to build on this natural motivation rather than try to introduce some form of highly structured, externally enforced regime.
- The majority of practitioners currently feel some affinity with their regulator. This sense of engagement enhances compliance, thereby reducing risk and costs. It is therefore important that the Act continue to support the strong, effective RAs with whom practitioners feel well connected.
- Like many other RAs, our Board devotes significant time and resource to positively and proactively guiding the profession. Feedback from our practitioners gives us confidence that these efforts are worthwhile and, most importantly, are likely to reduce risk to the public.

16. In the case of groups of practitioners that might be considered high risk, would it be useful for a risk-profiling approach to be applied by RAs?

- While we would need more information on what "risk-profiling" would entail, this seems to be an idea worthy of exploration. As Psychologists are somewhat unique in their career paths, often working very broadly in their scope and/or changing and expanding their field of practice, we would need to consider if and how risk-profiling would need to be adapted for our use.
- RAs can (and do) proactively address risk by analysing complaint and notification trends and subsequently publishing best practice guidance in various forms and forums. Such advice is also routinely garnered from our overseas colleagues, with whom we maintain strong and mutually beneficial relationships.

Cost effectiveness focus: The level of regulation is matched to the level of risk of harm to the public and ensures value for money is maintained

Overview:
The Psychologists Board strongly supports the idea of more explicitly including in the Act a requirement (principle) for RAs to carefully consider and to appropriately balance the costs and benefits of their regulatory activities. While this would clarify the requirement, it should be noted that Treasury and OAG guidelines already require RAs to consider cost, and that we would do so in any case simply because it is the right thing to do when spending practitioners' money. Public safety must always remain as our first priority, however, and that has a cost. The key, as has been identified elsewhere, is employing the "right touch".

In regard to defining the "right touch", the consultation document includes the following very useful quote:

> *The Government's policy framework for occupational regulation has the following three key assumptions:*
> - *Intervention by government in occupations should generally be used only when there is a problem or potential problem that is either unlikely to be solved in any other way or is such that it is inefficient or ineffective to solve in any other way.*
> - *The amount of intervention should be the minimum required to solve the problem.*
> - *The benefits of intervention must exceed the costs.*

With only slight modification these assumptions could be a useful start to defining for RAs just what the "right touch" is, and could be a part of the guiding principles we proposed above. They are also particularly instructive in considering whether the current structural arrangements deliver the best value for money and support workforce planning, and what (if any) large scale changes should be made. The very serious problems that have occurred with efforts to amalgamate RAs in Australia and the UK should amply demonstrate that huge costs sometimes result in only minimal benefits. We hope that we can we learn from their experience.

The consultation document suggests that our current form of statutory regulation is considered "an expensive way to ensure the public are safe from harm when accessing services". While we absolutely agree that costs need to be justified and (wherever possible) reduced, it is important to remember that *although effective regulation is expensive, ineffective regulation is even more expensive*.

Finally, and in regard to the collection of workforce data, we agree that such data can and should be captured by the RAs at the time of registration and annual renewal but believe that, as the data is to be collected for the Ministry's purpose, it is the Ministry who should develop and "own" the database. This would ensure that the data and database are fit for the Ministry's intended purpose, would reduce the risks inherent in gathering consistent, useful data over the longer term, and would also provide greater protection around the longer term retention and use of the data. We stand ready to submit the required data in the required form and also to be consulted on any other workforce intelligence that may be required.

Response to discussion document questions:

17. What role do RAs play in considering the cost impacts of their decisions and the cost benefits of regulation?

- An appropriately weighted consideration of costs has always been and always will be a key component of the Board's policy development and decision making. Consultation with our stakeholders and owners is also routine, and normally includes an analysis of the perceived costs and benefits of the options under consideration.
- RAs are already required to justify their costs, and this is closely monitored via our annual financial and performance (OAG) audits and via scrutiny by the RRC.
- The inclusion of a set of explicit guiding principles (including one or more in regard to the need to balance costs and benefits) might strengthen the Act.

18. Should the HPCA Act define harm or serious harm?

- While we agree that defining harm and serious harm could be useful, it is important to remember that any definitions must allow for some interpretation and flexibility as otherwise they may create legal lacunae (or worse). Ultimately this is a question best answered by legal experts.
- We also agree that establishing a threshold of risk would be difficult given the range of risk and circumstances that exist within and across professions and scopes of practice. And as there are "no tools for considering how to trade off risk of harm that is either unlikely to occur or is of short and non-permanent nature, with the benefit of better access to services", we believe there is a clear need to continue the direct involvement of the profession in these sensitive aspects of regulation. This is fundamental to ensuring regulation with the "right touch".
- The Board look forward to working with the Ministry and other RAs to develop a practical and flexible risk framework to underpin the Act.

19. Is HPCA Act clear about the level of risk that needs to be regulated by statute? If not, what would help to improve the match between level of risk and level of regulation?

- The Act is not clear in this regard, and could benefit (as noted above) from the inclusion of some explicit guiding principles.

20. Is the right set of regulatory options being applied to manage the risk of harm to the public that different health professions might pose?

- While we do not presume to fully appreciate the risks that other health professions manage (and therefore ultimately defer to their expertise), from what we are aware of it seems there are significant differences between the 22 professions currently under the Act. For example, we note that there is huge variation in terms of the frequency and seriousness of complaints and competence notifications received by each RA.[7] It is simply the case that one size does not fit all when it comes to Parts 3 & 4 of the Act, and that more than one regulatory option may need to be applied. This does, however, risk the introduction of multiple models and approaches, thereby potentially cluttering

[7] Perhaps due to the unique nature of their work and their relationships with their clients, psychologists attract a disproportionate number of complaints. This pattern has been noted in jurisdictions all around the world.

the sector and further confusing the public (with the result that regulation becomes less effective).

- We wonder if the principles developed for considering whether or not other professions should be brought under the HPCA Act could be applied retrospectively to the professions already included. Any subsequent proposal to "de-regulate" a profession should, however, be subject to broad consultation before any decision was made.

21. Could the way RAs administer their functions be improved?

- The RAs are always looking for opportunities to improve their performance and to reduce costs. The Psychologists Board has certainly made great strides under the HPCA Act and since setting up its own secretariat six years ago.
- The Board continues to consider options for a shared secretariat, with reference to principles that should ensure no loss of effectiveness. Those principles are:
  A. That each RA will be permitted (if they so choose) to directly employ and control any and all specialist 'regulatory' staff (i.e., those staff carrying out specialist functions under Parts 2, 3, and/or 4 of the Act). A corollary of this is that each RA will determine for itself who its specialist regulatory staff will be and how many it will employ at any given time.
  B. That each RA's current instruction and accountability chain is not lengthened.
  C. That each RA's regulatory decisions are all made by either the Board/Council or its delegate(s) (in order to ensure the on-going direct involvement of [psychologists] in these decisions).
- The Psychologists Board operates under a Policy Governance® system, and finds this to be both very cost effective and to significantly reduce risk. In contrast (and for various reasons), many of the other boards and councils have chosen to be more directly and routinely involved in their RA's day-to-day operations.[8] Particularly in support of a shared secretariat being established, it would be valuable for each board/council to review its governance approach (with reference to best practice) and to consider if it is using delegations to best effect.

22. Should RAs be required to consult more broadly with relevant stakeholders?

- Although at present the HPCA Act includes only minimal consultation requirements, it is our Board's usual practice to consult broadly (but in cost-effective ways) in regard to all significant policy, standards, and financial matters. This is formally monitored by the OAG and the RRC, and less formally by our stakeholders through our various links with them (e.g., newsletters, Annual Reports, website, conference presentations, meeting with major employers, and Psychology Professional Advisory Forum meetings). We do not believe that broader consultation is routinely warranted, and note that a cost/benefit balance must be struck.
- It could be useful, however, if the guiding principles we have proposed above included some reference to the Ministry's expectations re consultation.

[8] We note also that in the appendix re learnings from the UK one of the recommendations was "…improvements to the governance of the RAs, including: *creation of governance rather than what are effectively management boards and councils*". (emphasis added)

23. Should the number of regulatory boards be reduced, as in the UK?

- It appears to us that the UK situation was markedly different than what we have here in New Zealand, and that such extensive reductions here are both unnecessary and unwise. It may be possible, however, that some low-risk, "technical" profession RAs could be amalgamated, *if they were willing and had the clear support of their practitioners*.
- The list of the advantages arising from consolidations in Australia (AHPRA) is very thin and, based in part on the work done for the Partner RAs by KPMG, we believe these could be achieved in New Zealand by other (less disruptive, less risky, and less costly) mechanisms.
- In particular, we strongly believe that given (for example) the complexity and frequency of complaints and competence notifications we consistently receive psychology must not be lumped in with a large "Allied Professions" RA (as has happened with the HPC in the UK). Such a move would undermine our effectiveness by distancing us from our practitioners and weakening the strong affinity we have fostered.

24. What is the ideal size of RA boards?

- Research-based recommendations from the UK say the ideal size is 8 - 10. We have seen no other good research that supports anything less. On that basis we recommend that the starting point for appointments should be eight and that this should be increased or decreased only where sound and reasonable justification is provided. Ultimately the number of members appointed to any particular board should be based on a careful assessment of the needs of that board rather than on some pre-determined, arbitrary number.

25. Are there other issues you would like to raise?

- *Performance indicators:* The 2007 - 2009 review recommended that the Ministry develop, in consultation with RAs and others, a set of indicators to measure the effectiveness of the HPCA Act and to measure the performance of RAs. We remain very interested in assisting with this work and to learning from the CHRE reviews of the MCNZ and NCNZ.
- *Performance reviews:* If some RAs have established inadequate standards or policies that doesn't necessarily mean that there is a problem with the current Act. It may just mean that some further guidance and/or monitoring is needed. For example, regular reviews of each RA by a "CHRE"-like body (perhaps populated on a rotating basis by members and/or staff of other RAs) could be a low-cost, high-benefit, (and highly collaborative) approach.
- *Health services delivered via the internet:* Although perhaps beyond the scope of this review we note that, as it seems to require that all who practise in New Zealand register here, the HPCA Act does not adequately address the rapid proliferation of health services delivered via the internet.

Conclusion

The Psychologists Board believe that protection of the public must remain at the core of the HPCA Act. It may also be useful to make lower order purposes more explicit, and to include a set of 'guiding principles' to give effect to other important considerations (such as cost, risk, and workforce needs) and to ensure that RAs apply the "right touch". The Board also

believe that RAs should retain their current independent role in keeping the public safe, as it is a cornerstone of effective regulation.

We are confident that the recommendations arising from the current review (and the further consultation that will follow) can and will support better workforce planning and facilitate a shift to even more efficient and effective regulation. We look forward to working with the Ministry, our HRANZ colleagues, and other stakeholders to that end.

Contact

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