DENTAL COUNCIL
Te Kaunihera Tiaki Niho

Dental Council submission in response to the Ministry of Health *2012 Review of the Health Practitioners Competence Assurance Act 2003: A discussion document*

1.0 Introduction

1.01 The Dental Council welcomes the invitation from the Ministry of Health to participate in the public consultation process regarding *2012 Review of the Health Practitioners Competence Assurance Act 2003: A discussion document.* Council has carefully considered the information set out in the discussion document and has focused its submission as responses to each of the specific questions included in the document under the four identified principals of focus – future, consumer, safety, and cost effectiveness.

1.02. Council acknowledges the 2012 review is a strategic review, seeking to assess how the Health Practitioners Competence Assurance Act 2003 (the "Act") fits within the health system today, some nine years after the Act was introduced. The Dental Council considers the current regulatory environment is, substantively, working well. The Act is an example of 'enabling' framework legislation and as such, there is much that Responsible Authorities ("RAs") constituted by it, can do, if they so choose, to accomplish the purpose of the Act:[1]

> "…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."

1.03. Whilst the Act provides for a consistent accountability regime for all health professions it allows RAs to develop their own scopes of practice for determining a health practitioner's competence; and systems to ensure they do not act outside their scope of practice. The Act permits RAs to develop for the professions they regulate, relevant policies, codes of practice, recertification programmes, competence programmes, and health monitoring programmes. If the legislation was made too prescriptive this ability to 'self-regulate' would be needlessly lost.

1.04. The Dental Council supports 'framework' legislation and considers an enabling Act to be a positive feature of New Zealand's health regulatory system. RAs are equipped to develop and manage the detail of operational regulation. Enabling legislation reinforces the perception of self-regulation whereas prescriptive legislation would support a, less desirable, perception of regulation by government.

[1] Section 3(1), Health Practitioners Competence Assurance Act, 2003

2.0 Overview of the Dental Council

2.01 The Dental Council, one of 16 RAs established by the Act, has statutory responsibility for regulating five separate and distinct oral health professions-dentistry, dental hygiene, clinical dental technology, dental technology, and dental therapy. Dental specialists and orthodontic auxiliaries are included within those professions. Each of the five regulated professions, which comprise 20 scopes of practice, undertake restricted activities and each is separately accounted for and managed by the Dental Council.

2.02 The Dental Council has 13.5 full time equivalent staff members, four contracted professional advisors, and 10 Council members appointed by the Minister of Health. The Council itself is comprised of seven practitioner members - four dentists, one dental therapist, one dental hygienist and one clinical dental technician/dental technician - at least one of whom is an educationalist, and three lay members. Members are appointed for a term of up to three years and may be reappointed for further terms but may not serve for more than nine consecutive years.[2] Each year the Council elects a chair and a deputy chair. Since inception, the chair and the deputy chair have been practitioners. The Council is augmented by an Audit and Risk Management Committee chaired by an independent chartered accountant.[3]

2.03 The Dental Council is committed to the promotion and protection of the public interest by ensuring that registered oral health practitioners are safe and competent to practise their professions. It seeks to provide public assurance of safe delivery of oral health care and to provide oral health practitioners with a framework to deliver best practice oral health care for the public of New Zealand.

2.04 The goals of the Dental Council are to:

- administer the Health Practitioners Competence Assurance Act 2003 consistently, fairly and effectively;
- maintain an organisation that is efficient, responsive and sustainable;
- promote and communicate Council's functions to stakeholders and the public of New Zealand; and
- promote best practice and well respected standards of oral health care.

2.05 As at 31 March 2012, 4,553 oral health practitioners were registered with the Dental Council, of whom 3,771 held annual practicing certificates. These represent increases of 3.7 percent and 2.2 percent respectively from the previous, 2010/11 practising year.

2.06 The greater majority of oral health practitioners work in the private sector – 92 percent of dentists and dental specialists; 94 percent of dental hygienists; and 92 percent of dental technicians and clinical technicians. The exception is dental therapy, in which profession 83 percent are employed by District Health Boards. Overall, 74 percent of oral health practitioners work in the private sector.

2.07 During the 2011/12 financial year:

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[2] Section 121(2), Health Practitioners Act, 2003

[3] Appointed under clause 16, Schedule 3, Health Practitioners Competence Assurance Act, 2003

- The cost of regulation (including disciplinary action) to the Dental Council was $2,989,980.
- Council received 44 complaints from various sources including, consumers, Health and Disability Commissioner, health practitioners, employers, and notices of conviction from the Courts.
- Council referred two practitioners to competence review.
- Council referred six practitioners to professional conduct committees for reasons including, fraud, notification of conviction, practising outside scope, and practising without an annual practising certificate.
- Four practitioners were referred by professional conduct committees to the Health Practitioners Disciplinary Tribunal.
- Council imposed conditions on the scope of practice of 10 practitioners for reasons including, competence related supervision, and the rehabilitation of a health-impaired practitioner.
- The practising certificate of one practitioner was suspended by Council.
- Council undertook nine public consultations on a wide range of matters including, the future of the specialty of oral surgery in New Zealand; budget, fees and disciplinary levies; a new code of practice on advertising; prescribed qualifications; scope of practice changes.

3.0 Future focus

Ministry of Health Statement

> *"To sustain our health service New Zealand needs to be able to attract and retain a workforce that delivers services within a lower growth funding path, in the context of an ageing workforce and significant numbers leaving for overseas in any one year. Our current services are mainly configured around historical patterns of population demand and traditional models of care that are labour intensive and expensive to sustain.*
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> *To meet these challenges we need to move away from a focus on hospital services and admissions and towards better, sooner, more convenient service delivery through the integration of primary care and other parts of the health service. The core safety function of the HPCA Act needs to be balanced against ensuring that its indirect (but strong) influence on the shape of the workforce matches the needs of a changing sector.*
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> *In line with usual regulatory governance structures, responsible authorities (RAs) are set up to work independently, and yet the requirements they place on health practitioners shape how they practise in order to remain within their professional and legal requirements. This document looks at how RAs can ensure that their requirements for health practitioners keep pace with what the sector needs in an environment that is undergoing transformational change.*
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> *Although regulation is generally managed along professional boundaries, these boundaries are increasingly shifting and becoming less distinct in complex clinical environments. Consumer care and the protection of consumer safety are increasingly dependent on how multidisciplinary teams and clinical networks operate.*
>
> *The key value underpinning the HPCA Act is the accountability of individual health practitioners for their own clinical practice and application of professional judgement in their clinical practice. The Challenge is to ensure this key value operates effectively in a changing environment.*
>
> **The Act needs to balance its core function of protecting the safety of the public with its ability to influence the shape of the workforce and meet the needs of a changing sector."**

3.01 Introductory statement

The desired move to support workforce development and flexibility by shifting a focus on hospital services and admissions to enhanced service delivery through the integration of primary care and other parts of the health service, appears geared towards the public sector environment. The vast majority of oral health practitioners regulated by the Dental Council do not work in the public sector and the majority of oral health care is currently delivered in the primary oral health care environments of private dental practice and community dental services. The Ministry must be alert not to narrow its focus – are the issues of the publicly funded health sector and particularly the issues of the delivery of primary and secondary medical services, necessarily relevant to health professional regulation for the privately funded and associated sectors of health, such as oral health?

Shaping the workforce in a changing sector is a role of education providers working in consultation with the health sector and government. Scopes of practice

set by RAs are not the key barrier to enhancing integrated care. Funding pathways, the structural design of health services and systems, and genuine safety concerns are greater barriers to integrated care than the Act or scopes of practice. Caution must be exercised if legislation is to be amended in the hope that such amendment will be the catalyst for enhancing integrated care.

The Act is enabling; RAs may do 'more' to address the needs of the workforce in a changing sector. However, there are restraints on the way RAs operationalise the Act given the existence of the non-alignment of the objectives of Health Workforce New Zealand, the service providers, and the education providers. Greater guidance and disclosure from government agencies will be more useful than changing the current legislation.

The Dental Council does provide some care to its practitioners to support their health and competence. However, the Dental Council does not support a mandated pastoral care role for RAs. Introducing a statutory duty for RAs to undertake pastoral care of practitioners fundamentally conflicts with the RAs primary role as regulators.

The consolidation of RA secretariats would serve to support integrated care that will achieve best outcomes for the public. A degree of standardisation of codes of conduct, ethics and, in some areas, common learning across health professionals could be achieved by RAs working collectively in a single secretariat.

Question 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 Act improve this?

3.02 The Act provides a framework within which RAs are tasked with protecting the health and safety of the public by providing mechanisms to ensure practitioners are competent and fit to practise.[4] Beyond the bounds of individual practitioner competence and fitness to practise, and the mechanisms established by RAs for that purpose, the Act as it is currently drafted has no role in regulating service delivery, whether integrated or otherwise.

3.03 The fundamental problem of improving care and service models does not lie with the Act. It is a far larger issue concerning the overall structure of the health system, including funding and education. RAs cannot address the wider system issues, their focus being on the competence and fitness of individual practitioners not the structure and operation of the system which delivers services; that is the role of government. Health Work Force New Zealand ("HWNZ") is the crucial link between the delivery of services and a health workforce that is fit for purpose.

3.04 It is not the role of RAs to produce a 'fit for purpose' workforce by prescribing courses of education or learning that meet the forecast service delivery needs of HWNZ. This is the role of the education providers, working in consultation with the health sector including HWNZ.

3.05 RAs are required by the Act[5] - to promote education and training in the profession; to prescribe the qualifications required for scopes of practice within the profession, and for that purpose, to accredit and monitor educational

[4] Section 3(1), Health Practitioners Competence Assurance Act, 2003

[5] Section 118, Health Practitioners Competence Assurance Act, 2003

institutions and degrees, courses of studies and programmes; and, to recognise, accredit and set programmes to ensure the ongoing competence of health practitioners.

3.06 The *Discussion Document* notes that *"…RAs influence the shape of the workforce through how they set qualifications [and] scopes of practice…"* The setting of prescribed qualifications for scopes of practice is to a very large degree dependent upon what qualifications are offered by education providers to sensibly underpin those scopes of practice. RAs have little, if any, ability to influence education providers in determining the courses of study they offer; they being geared to meet their own objectives, which are not necessarily aligned with those of either the RAs or the Ministry of Health. Accordingly, course development by education providers, frequently dictates the shape of scopes of practice – not vice versa. The 'drivers' for course delivery need to be revised to ensure workforce service delivery requirements dictate the development and offering of courses by education providers.

3.07 RAs can have some influence on the achievement of best outcomes for patients through integrated care by the establishment of broadly drafted scopes of practice that permit the flexibility to enable service delivery requirements to be met. This ability currently exists under the Act and accordingly no amendment is required.

Question 2

How can the Act be used to promote a more flexible workforce to meet emerging challenges faced by the health system?

3.08 The *Discussion Document* notes that one of the original objectives of the Act was to encourage greater inter-professional collaboration and increased workforce flexibility. It was anticipated that the use of overlapping scopes would contribute to this, and a mechanism for resolving scope of practice disputes between RAs was provided.

3.09 The term 'Scope of Practice' is used internationally by national and state/provincial registration and licensing boards for various professions to define the procedures, actions and processes that are permitted for the registered/licensed practitioner. A scope of practice is limited to that which the law allows for specific education and experience, and specific demonstrated competence. Each jurisdiction has laws, registration or licensing bodies, and regulations that describe requirements for education and training, and define scopes of practice.

3.10 It is generally accepted that scopes of practice can be easily identified by three categories. If requirements for practising the skills of a profession satisfy all three requirements then it is within a practitioner's scope of practice:

- Education and training – has the practitioner been educated academically or on-the-job and does the practitioner have documentation proving education to perform the procedure in question?
- Regulating body – does the regulatory body that oversees the skill or profession allow (or explicitly disallow) the procedure in question?
- Institution – does the institution allow a person or their profession to perform the procedure in question?

3.11 The Dental Council regulates five oral health professions which are very much vertically integrated, with scopes of practice overlapping, a number of them quite significantly. Scope overlap also exists between the oral health professions and other health professions – for example, the Oral and Maxillofacial Surgery scope of practice overlaps with the medical scopes of Plastic Surgery and Ear Nose and Throat specialisation.[6] There has been no cause to invoke the dispute resolution provisions of the Act, as RAs have been able to satisfactorily negotiate overlapping scopes without difficulty. The real issue with overlapping scopes of practice is not that they do not overlap or are not complementary, but the inherent 'patch protection' that practitioner groups seek to assert to protect or reinforce their professional and market pre-eminence. This is very evident not only between some oral health scopes of practice, but also between certain oral health scopes of practice and those of other health professions. The professional friction generated by overlapping scopes of practice gives rise to a substantial number of complaints, all of which must be investigated in accordance with the Act, at considerable cost. Such issues led to protracted and expensive litigation when the Dental Council recently sought to clarify a specialist scope of practice.

3.12 With 92 percent of dentists in private practice, the Dental Council is of the view that whilst an increase in the degree of commonality and standardisation across professional groupings would facilitate professional flexibility, it may also increase professional tensions and animosities as professional groups seek to assert themselves.

3.13 In its current form, the Act permits RAs to address the needs of the workforce and its changing face through their ability to develop scopes of practice as considered necessary. Change in that regard, is not needed. However, from a practical perspective, RAs do not have the ability to do so, because scopes of practice are essentially dictated by the courses of study offered by education providers. To address the needs of the workforce and its changing face, the drivers of education need to be changed to ensure that the health needs of the community and the consequent workforce requirements dictate the nature of the courses of education being offered. It is important to recognise that RAs neither forecast nor direct the utilisation of the workforce – those responsibilities lie with HWNZ and with the service providers (whether institutional, corporate or private practices). Nor is it the responsibility of RAs to plan and offer courses of education – that is the responsibility of tertiary education providers. Until there is an alignment of the objectives of HWNZ, service providers and the education providers, the ability of RAs to practically address the needs of the workforce and its changing face by developing appropriate scopes of practice, will remain largely illusory. This is not a matter that can sensibly be addressed by the Act.

Question 3

How can the 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?

[6] Oral and Maxillofacial Surgeons, being both oral health specialists and medical specialists hold dual registration with the Dental Council and the Medical Council of New Zealand

3.14 The promotion of education with a wider focus is not a matter that sits within the ambit of the Act, and nor should it. Such promotion sits elsewhere within the structures of the wider health system. In the oral health sector a significant separation exists between the training, regulation and service delivery environments. To illustrate for example, the Dental Council as a single RA regulates multiple professional groups. Although the training of dentists, dental specialists, therapists, hygienists, clinical dental technicians and dental technicians is principally provided by one education provider, there has been no noticeable improvement in teamwork across the distinct professions. The barriers between them appear to be a consequence of entrenched professional attitudes existing not only within the education sector, but also within practitioner and service delivery environments.

3.15 Whilst most oral health professionals have not, and are most unlikely to, ever work in the sort of team environment alluded to in the *Discussion Document*, there is a very limited number of general dentists and dental specialists employed by, or consulting to DHBs, who do. The Act currently focuses on individual practitioner competence and accountability, and as such does encompass the practitioner's professional working relationship with his or her colleagues of other professions.[7]

3.16 In an effort to broaden the focus of the education and training it offers, an education provider introduced a degree course (Bachelor of Oral Health) encompassing two separate professions – dental therapy and dental hygiene. Unfortunately this has not proved to be a combination of skills required by or embraced by the sector. Hygienists currently have limited application in the public health environment and dentists in the private sector have limited scope to employ dental therapists. Neither sector has embraced the dual qualified 'dental therapist-dental hygienist' graduates, and accordingly most are only able to find employment in one scope. As a consequence of being unable to practise in both scopes, recency of practice constraints will result in them having to relinquish one of them. In theory these dual scope practitioners could help meet the oral health needs of a changing New Zealand population and application of their skills has not been constrained by the Act and its provisions. Rather professional boundaries, service models and funding streams have been greater limiting factors. Clearly there needs to be a dialogue between the HWNZ, service providers and educators to achieve the right balance for meeting workforce needs and with professional groups and stakeholders to address the professional and inter-professional barriers that exist.

3.17 The introduction of the Bachelor of Oral Health has provided one positive. Each of the two scopes of practice it encompasses has as a result of the introduction of degree courses for dental hygiene and dental therapy, been 'upgraded' to include a number of procedures that were previously only available as separate courses of study and recognised as 'add-ons' to each of the principal scopes. The principal scope in each of the two professions has now been set to incorporate all of the 'add-ons', with restrictions being recorded where a practitioner has not completed the requisite training to merit the full scope. This has proved to be a positive incentive for those practitioners with restrictions on their scope of practice, to up-skill.

[7] With the exception of dental hygiene and dental therapy, each of which have Professional Agreements with dentists to define and govern their working relationships

Question 4

Is there scope for the Act to better address the standardisation of codes of conduct, ethics and common learning across health professionals?

3.18 Codes of conduct are in effect the minimum standards of conduct that are acceptable to a particular profession. In each case there will be commonality; however there will likewise be differing standards applicable to different professions. This is made particularly apparent by decisions of the Health Practitioners Disciplinary Tribunal under section 100(1), subsections (a) and (b) of the Act, relating to misconduct amounting to malpractice or negligence, or misconduct that has or is likely to bring discredit to the profession. Whilst the Tribunal does take into account the Codes of Practice of the relevant profession, it does apply its own thinking and, for example, will view a charge of fraud or assault against a dental specialist or doctor differently than if the same charges were being considered against a dental technician or a laboratory technician. Because of their trusted position in the community, a higher standard of care is applied to the former. Such a differentiation is one of a number of factors taken into account by the Tribunal. It is considered that because of such factors a universal codification of minimum standards of conduct is neither practical nor desirable.

3.19 Is it appropriate that the same ethical standards are applied to health practitioners who are not directly dealing with the public or working in a team environment (for example dental technicians or laboratory technicians), as may be applied to those front line professionals working in teams, and/or dealing directly with consumers? Whilst it may be possible to achieve some commonality, universal ethical standards and codes of conduct, would be unduly harsh on some professions.

3.20 Many of the health professions have very little learning in common with other professions, if any. There is limited commonality amongst some, for example, dentistry and dental therapy, where the differentiation is the degree and the extent of learning. There is also commonality in courses that oral health professionals are required to undertake on a regular basis, for example resuscitation.

3.21 Improved standardisation could be gained through a consolidation of RA secretariats. A single secretariat would of necessity focus on the development of best practice across all standards and codes.

Question 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?

3.22 On one hand we have broad scopes of practice set by RAs to understand the range of health services a registered health practitioner may provide. On the other hand the Health and Disability Commissioner has a code of rights serving as a mechanism to inform the public what they can expect from health service delivery. These features together offer a balance for public expectation

3.23 On the other hand, a natural tension exists between the competing objectives of scopes of practice, which has led to diametrically opposed approaches to their definition – the prescriptive versus the broad or principles based approach. Prescriptive scopes of practice are defined often by reference to commonly performed tasks or patient conditions so as to enable clear unequivocal boundaries to be established. With clear boundaries, issues of competence can be more easily determined; there can be no excuse for practising outside of a scope and, consumers can have more confidence in practitioners' competence because they practise within clearly defined parameters. Conversely, prescriptive scopes may be seen as inhibiting practitioners, and therefore workforce flexibility; and may be viewed as too rigid and at risk of becoming out of date.

3.24 Broad or principles-based scopes of practice, may on the other hand bring service delivery flexibility, but at the same time inhibit consumer confidence, providing insufficient clarity for the consumer to be assured of a practitioner's competence.

3.25 The most commonly adopted approach for creating the parameters of a broadly drafted scope of practice is, to define the scope by reference to the practitioner's education and learning.

3.26 The Dental Council has twenty scopes of practice relating to dentistry (1), dental specialties (12), dental therapy (2), dental hygiene (2), clinical dental technology (2) and dental technology (1). The scopes for general dentistry and the dental specialties are generally broad-based and permissive, whilst those for therapy and hygiene are prescriptive, reflecting that they are subsets of dentistry. The scopes of practice for hygiene and therapy comprise a general statement of the scope followed by detailed description which is boundary rather than competence based, and restrictive in nature.

3.27 The Dental Council provides extensive information to consumers on its website[8] including information on "*Confidence in your Practitioner*", "*Concerns and Complaints*", "*Consumer Rights*", "*Oral Health Education*", "*Definitions*" and "*Frequently asked Questions*". The Council website also includes a search engine to enable consumers to "*Locate a Practitioner*", a service which lists practitioners by name, address and scope of practice giving the following information:

Name:	**Goodhew, Peter Mark**
Address:	50 Church Street Timaru 7910
Contact:	Phone: 03 684 3451 Fax: 03 684 6034 Email: timarudentalcare@xtra.co.nz
Qualifications:	BDS 1984 Otago
Scopes of Practice:	General Dental Practice
Conditions on Practice:	No
First Registered:	18 April 1985
Reg Number:	DD2177
HPI Number:	10BALG

[8] http://www.dentalcouncil.org.nz

Practising Status:	May practise in registered active scope(s) of Dentistry subject to current APC
APC Status:	Dentistry - Current APC held - Valid from 01 October 2012 to 30 September 2013

There is, however, some scepticism as to how extensively these services are utilised by the public.

Question 6

Could RAs have a mandated role in health professionals' pastoral care? If so, how can they carry this out?

3.28 There is a philosophical question of whether '*pastoral care'* is an appropriate function of a regulatory body which has as its primary objective the safety of the consumer. There is a very significant tension, to the extent of being a fundamental contradiction, between the concepts of professional regulation and that of the regulator providing pastoral care to the practitioners it regulates. Such a proposal is in fundamental conflict with the primary function of the regulator to ensure the safety of the consumer, and must be distinguished from the 'duty of care' that RAs may owe practitioners, which is quite different to the concept of providing pastoral care. Where does the primary responsibility lie – to the consumer or the practitioner? Where the interests are in conflict, the public safety interest must prevail.

3.29 When dealing with practitioners, RAs owe them a duty of care to act appropriately and fairly. '*Appropriateness*' may entail guiding or referring a practitioner to an organisation or individual who can provide the level of personal or professional support commensurate to size and the nature of the problem that the practitioner is facing. The Dental Council takes such a duty extremely seriously, but is acutely aware that in common with other RAs, it has neither the expertise nor the capacity to provide personal or professional support to practitioners.

3.30 As a function of protecting the health and safety of the public, RAs can and do play an active role in 'pastoral' care. This can best illustrated in the manner in which the Dental Council manages the cases of practitioners who are or have been suffering from illness, or a physical or mental incapacity. In all but the most extreme cases Council utilises a Voluntary Agreement process to support and manage a practitioner's ability to safely remain practising or their safe return to practice. Under a Voluntarily Agreement a practitioner may be required to abstain from or to do certain things, including for example: working limited hours; practicing under clinical supervision; undertaking regular medical consultation with an approved medical practitioner; undertaking a blood or urine screening programme; providing psychiatric reports.

3.31 Currently 90 percent of the practitioner health issues that come to the attention of Council are managed outside the statutory regime, primarily via Voluntary Agreements with the practitioner. The objective is to assist the practitioner to practise safely whilst they return to full health; allowing them to retain their dignity free of the implied threat of statutory action being initiated, and without the necessity of imposing conditions on their scope of practice and the adverse 'publicity' that can result.

3.32 The Dental Council sees no benefit in codifying the Voluntary Agreement practice as to do so would remove inherent and necessary flexibility. Compulsion would adversely impact on practitioners' dignity in Council's view unnecessarily, at a time when their self-confidence is generally very low. Developing carefully considered principles-based policies may assist some RAs management of practitioner care matters.

3.33 In addition to the Voluntary Agreement regime, Council endeavours to support isolated practitioners, as they are a sector of the Workforce identified as more at risk than others, through its compulsory recertification programme. This it does by requiring all practitioners to meet a prescribed level of peer contacts over each Continuing Professional Development cycle. This is of primary benefit to sole practitioners, particularly those who are geographically isolated. Those practitioners who are in group practices or are employed tend to have collegial support available.

3.34 A proposal that RAs undertake practitioner pastoral care assumes that practical statutory mechanisms to require the RAs to be alerted to the need for pastoral care intervention could be satisfactorily devised and implemented. Council is aware that it has a low visibility of such needs, because Council is seen by practitioners as a regulatory body to which the admission of personal issues by practitioners is to be avoided rather than embraced: not as a professional association, where such matters are better managed.

3.35 The Dental Council is of the view that a statutory duty to undertake practitioner pastoral care would be fundamentally incompatible with an RAs primary obligation of protecting the health and safety of the public. In addition, because RAs do not having the necessary expertise or capacity to engage in pastoral care activities, such a proposal would require the engagement of additional, trained staff at significant cost.

4.0 Consumer focus

Ministry of Health Statement

> *"The views of consumers and the public generally will be an important input into this review, particularly views on how confidence in the safety of health and disability services can be maintained and enhanced and whether consumers have access to the necessary information to make good decisions about health practitioner. A consumer focus requires transparency of information and processes, and appropriate representation in the regulatory processes.*
>
> ***The Act needs to balance health professional expertise in managing risk of harm to the public with the public's rights to be well informed and involved in how the Act operates".***

4.01 Introductory statement

Consumers do have involvement in decision-making to varying degrees under the current legislative framework. However, it is the experience of the Dental Council that consumer 'up-take' of involvement in decision-making is at a negligible level. In general, the public does not exercise its right to be involved in the regulatory regime other than at a low level. The establishment of consumer forums may address the deficiency. However, the issues of cost and scale – having enough work to keep an informed trained consumer group occupied - may counter any benefit to be gained.

It is vitally important, when considering the balance of lay people to health professionals in the governance structure of RAs, that the focus is on the level and balance of skills of representatives, rather than a simple numerical ratio. The focus must be bringing together a combination of skills to ensure unbiased decision-making, focus on patient safety and maintaining confidence in regulation.

The Act operates effectively to keep the public safe and there is good access to necessary information to enhance the safety of the public. There are some areas where there could be an improvement of transparency of information to the public, for example, a complaint made by a consumer that is directed to the competence regime. In that case, in the interest of not breaching a practitioner's right to privacy, the public's ability to access certain information has been compromised. Enhanced consistency as to what information can be released to consumers under the Act may be achieved by a consolidated single secretariat for all 16 RAs.

Question 7
Does the Act keep the public safe, involve consumers appropriately in decision-making and assist in keeping the public informed?

4.02 There are three elements to this question. The first element for consideration is: *Does the Act keep the public safe?* In the view of the Dental Council the answer is yes. The Act is proactive and operates successfully to protect the health and safety of the public. It provides mechanisms to ensure that practitioners are competent and fit to practise. It provides the framework to enable regulatory authorities to establish a consistent accountability regime through registration, recertification and the establishment of standards by mandating the establishment

of scopes of practice within which practitioners remain up to date; and by assuring the quality of professional education and qualifications.

4.03 The Act also keeps the public safe by empowering regulatory authorities to review and determine whether a practitioner's competence meets the required standard and where necessary, to enforce remediation; and to retrospectively initiate disciplinary action where practitioner conduct or performance warrants it.

4.04 Public safety may be further enhanced by tighter controls on registration requirements. For example, requiring a pre-registration year of practical experience for new registrants to minimise potential issues that emerge when new registrants go into unsupported practices and competence concerns arise due to clinical inexperience. However, the current Act already allows regulatory authorities to develop their own policies to address such issues and therefore, tighter legislative control is not needed to enhance public safety.

4.05. There are a number of areas, however, where the Act could be significantly streamlined without impinging on practitioners' rights, whilst saving both time and costs.

4.06. The second element to be considered is: *Does the Act involve consumers appropriately in decision making?*

4.07 Having made a complaint which is directed to a competence consideration, the complainant has no further part to play. The process of a competence inquiry under the Act is not a judicial hearing but rather, a process focused on identifying whether there are any gaps in the practitioner's knowledge or clinical performance. It would be appropriate to involve the complainant if competence was managed in a judicial manner with particularised charges, each of which was required to be proved by the regulatory authority. However, that approach is fundamentally at odds with the concept of the competence regime. Accordingly, it is entirely appropriate that the complainant does not participate in competence inquiries or determinations, but should, however, be informed of the outcome.

4.08 Having made a complaint which is directed to a professional conduct committee ("PCC"), the complainant may be called upon by the PCC to supplement the evidence provided in the complaint, and is advised of the outcome by the PCC. In the event the PCC lays charges against the practitioner before the Health Practitioners Disciplinary Tribunal ("HPDT"), the complainant may have the opportunity to give evidence before the Tribunal, and is advised of the outcome. In short, the complainant has the same level of involvement that a victim could be expected to have in a criminal proceedings.

4.09 Consumer input in the decision making process is incorporated at a wider level through the Dental Council's consultation processes. It is also open to the public to communicate with RAs on matters which concern them, specifically or generally, and therefore, to varying degrees consumers are involved in aspects of decision making. It is the experience of the Dental Council however, that it is practitioners and professional associations who respond to consultations – not the public.

4.10 The Dental Council recognises that consumers can make contributions to health systems and processes; and as 'consumers' they should have the right to do so. Under the current legislative framework consumers do have involvement in decision making. It is also to be recognised that the public is not as informed as it

should be on matters concerning health and safety which affects their ability to provide erudite input into decision making. The Dental Council does not support a legislative requirement for a high level of public consultation where there is significant risk of contributions being ill-informed and therefore, of limited usefulness. This is particularly so because RA Councils and Boards have a 'consumer' membership component of between 25% and 33%

4.11 The third element to be considered is: *Does the Act assist in keeping the public informed?* Mechanisms to keep the public informed are provided for in the Act but the degree of effectiveness is debatable.

4.12 Complainants are generally not advised of the outcome of their complaints unless they participate in a PCC or there is a Tribunal hearing. The reason for this is the privacy of the practitioner. However, the validity of this is moot. The challenge faced by regulatory authorities is the level of information that can be revealed to a complainant without compromising the integrity of the process or otherwise breaching the rights of a practitioner involved in the particular circumstances. RAs are also acutely aware that the fact of a competence review can be potentially more damaging to a practitioner's professional reputation than an adverse determination by a PCC or the HPDT. This is because many practitioners facing competence reviews feel they are legally disadvantaged because particularised charges are not laid which they can defend. They see it as a breach of natural justice that there can be an inquiry into their competence, to which there is no means of defence. Council is aware that that there is a will within the legal profession to judicially test the efficacy of the competence regime.

4.13 The Act does not require RAs to provide the consumer with details of the outcome of a complaint or the reasons for it. Competing interests exist for RAs between respecting the reputation of the practitioner; the consumer's interest to be informed; and RA efficiency. If there is a desire to keep consumers better informed of the outcomes of their complaints, the Dental Council suggests the HDC may be better placed as a 'one stop shop' to notify consumers of the outcome of their complaint about a health practitioner.

4.14 In terms of disciplinary outcomes, the results are posted on the Dental Council website; and with competence, where the practitioner's scope of practice is altered by the imposition of conditions this is recorded on the publically available register on Council's website. HPDT decisions are published and the practitioner named unless there is a suppression order. Disciplinary outcomes are also published in the Dental Council newsletter.

4.15 The overall experience of the Dental Council is of a low level of consumer interest and participation, through consultation responses; direct contact from consumers concerning personal and wider industry issues; or, lobbying by interested group. The Act provides mechanisms for involving consumers in decision making to variable degrees. Current legislation does not prevent RAs from seeking greater involvement of individuals in the progress and outcomes for practitioner issues.

4.16 Council acknowledges there is room for improvement with regard to keeping complainants informed and across the spectrum of information disclosure. However, such improvements do not require legislative reform as they are operational matters which may be addressed within the framework of the current Act.

Question 8

Is information from RAs readily available, particularly as it relates to practitioners and the transparency of complaints and complaint process? If so, is this information made good use of by the public?

4.17 The Dental Council website is a key source of information for the public. General information targeted to consumers includes, information about the Act and the benefits to consumers; help and advice for dissatisfied consumers and the complaints process; information about consumer rights, special topics, and oral health education; definitions; and frequently asked questions. Consumers can also look up registered practitioners on the website and find out whether they hold a current practising certificate; their scope of practice and any conditions on their scope. There is no public record advising a practitioner is the subject of a complaint or under investigation. If conditions are imposed on a practitioner's scope as a competence measure or for any other reason, the condition is made public but not the reason for its imposition, although this may be apparent from the nature of the condition. As already noted in the response to question 7 above, disciplinary outcomes are published on Council's website and newsletter. A statistical overview of complaints and discipline is included in the publically available Dental Council annual report.

4.18 Council has no substantive knowledge whether the information it publishes is put to good use by the public or whether it is utilised at all. The only evidence of the use of Council published information is occasional reference to it by the media.

4.19 More could be done by way of a public campaign to alert the public to Council's website and the ability to search a practitioner on the publicly available register to verify his or her suitability. The public could be encouraged to be better informed when selecting a health practitioner. A public marketing campaign would, however, result in a significant cost to the regulating authorities, and consequently to practitioners. The Dental Council considers such campaigns may best be promoted by the Ministry of Health, alerting the public to the available information provided by RAs concerning health practitioners.

4.20 The transparency of complaints and the complaints process is discussed in paragraphs 4.07 – 4.16.

Question 9

Do we have the right balance of laypeople to health professionals on RA boards?

4.21 The United Kingdom practice suggests parity of public membership on Councils and its committees is important in ensuring unbiased decision making, focus on patient safety and maintaining public confidence in regulation. Greater lay representation on Councils sends a message that the regulators' priority is public protection, not professional protection. The move in the United Kingdom has been to both reduce the size of the Councils (General Dental Council down from 24 to 12 and similarly with the General Medical Council) and to introduce lay chairs who are appropriately qualified/recognised business people. It has been recognised to a limited degree in the United Kingdom that it is fundamental to the achievement of efficiencies that the appropriate skill sets be brought to bear.

4.22 In terms of the ratio of lay representatives to clinical members, currently established by section 120(2) of the Act as between 25 percent and 33 percent; that is probably appropriate. It is noteworthy, however, that the Dental Council is in a somewhat unique position in that 10 Council members regulate five distinct professions under the Act. Seven of the Council members are clinical members drawn from each of the five regulated professions, and three are lay members. Council functions very efficiently which suggests that other regulatory authorities with a similar number of members, but regulating only one profession may be over endowed. It is also worthy of note that upon the inception of the Act, 14 members were appointed to Council, a number that has with the agreement of the Minister of Health been progressively reduced to the current number of Councillors, which Council now considers optimum for the current level of business before it.

4.23 Council considers it is the level and balance of skills that lay members bring to the table, rather than the application of a simple ratio formula that is critical to the success of a Council or Board. Lay membership should provide considerably more than being a bare community conscience. Business, legal, accounting and recognised community leadership skills should be prominent in the mix to balance those appointed because of their clinical backgrounds. Likewise an ethnic and gender balance is and should continue to be a consideration of the appointments process. Appropriately qualified or experienced lay members are quite capable of providing the necessary social conscience, gender and ethnic balance whilst at the same time bringing their qualifications and experience to bear on Council's business. It must not be overlooked that whilst authorities regulate the professions, they are also not for profit businesses, exhorted by the Government to regulate to the required standard at the lowest possible cost. Being funded by their professions, regulatory authority Councils or Boards have a fiduciary duty to registered practitioners. Accordingly, the appropriate skill set in lay representatives on Councils and Boards is essential. Greater organisational diversity and equality is desirable in the governance structure of regulating authorities.

4.24 RAs must assert their independence of the profession(s) they regulate and accordingly any perception that they have been 'captured' by, or in any way tainted by any particular professional or lobby group carries with it perception of cronyism and industry representation and must be avoided.

4.25 One question that hasn't been posed, but is fundamental to any review of Boards and their structure, is what the function of the Board is? In noting that the size of UK boards has been halved, what has to be taken into account is that the UK Boards, like their counterparts in Australia undertake a purely governance function. Accordingly it is important to recognise, that the United Kingdom and Australian examples are not entirely relevant to the New Zealand situation and thus, must be treated with caution. Practitioner numbers in New Zealand dictate that the composition of RA Councils and Boards include sufficient practitioners to not only undertake a governance role, but to also undertake an 'operational' role in the consideration and determination of registrant and practitioner issues. If sufficient practitioner Council members were not available to undertake such 'operational' decision making, then appropriately qualified and experienced practitioners would have to be employed, at significant additional cost. Most RA

Boards in New Zealand undertake both governance and operational activities, with more than 50 percent of their working time engaged in the latter.

4.26 Whilst the function of RA Councils and Boards is driven by practitioner numbers in New Zealand and the resultant small, cost contained RAs, an amalgamation of secretariats will not result in Boards or Councils relinquishing the operational role they currently undertake. This is because the cost of employing the number of appropriately qualified and experienced practitioners to undertake that operational work would be prohibitive, severely impacting any savings achieved by amalgamation.

Question 10

Should New Zealand consider introducing consumer forums, where the public can communicate with RAs on matters that concern them, as in the UK?

4.27 In the United Kingdom, the Council for Health Regulatory Excellence (CHRE) established a public stakeholder network in 2009 as a free virtual network of users of health and social care services and the public. Its purpose was to help the CHRE promote excellence in the way regulatory authorities are regulated. In endeavouring to attract membership and participation they offered training and support, and financial assistance to members to attend meetings. A series of meetings of the stakeholder network were held in 2010 attended by 170 participants principally representing patient and human rights groups. The proposals to come out of these meetings focused primarily on complaints systems, and its lack of transparency leading the CHRE to announce it would:

- work with regulatory authorities to design a common data set to make it easier to measure and where appropriate, to compare RA performance, including complaint statistics;
- invite regulatory authorities to work with the CHRE to identify ways they could work together or share information to make regulation more efficient and cost effective; and
- investigate the feasibility of establishing a single portal for complaints, including how to navigate the complaints process, how to set out a complaint, and sources of support.

4.28 The English health and regulatory system operates in quite a different environment to that of New Zealand, and the question must be whether the costs of the establishment and servicing of such a forum would achieve anything that is not already achieved? It is also suggested that an examination of membership of the CHRE stakeholder group reveals that it is not truly representative of the public interest, but is a collection of representatives of particular interest and lobby groups.

4.29 The matters raised as concerns by the CHRE consumer network, are amongst the questions raised for discussion in the Ministry's current discussion document – particularly those relating to the transparency of regulatory authorities' complaints processes and the desirability of a common dataset.

4.30 Consumer forums or councils are also utilised in Australia. There is some evidence indicating Australia is better than New Zealand in having structures in place to ensure consumer input into health systems and processes, and like the

CHRE stakeholder group, they provide training and resources to consumers to facilitate their strong and informed participation.

4.31 Whilst there may be some value gained in New Zealand from a consumer reference forum, the challenge would be how to structurally implement one. Barriers include the likely high cost and that there would be insufficient substance in oral health regulation to keep a consumer reference group constructively occupied. To have a consumer reference group convene infrequently would be counterproductive, because significant time would be required at each meeting in 're-educating' the group.

4.32 Bearing in mind that the Act focuses upon individual practitioners, if consumer feedback on the operation of the health system is what is desired, then that would sit outside the proper function and ambit of RAs. Consumer advocacy would sit better with an organisation such as Ministry of Consumer Affairs. Alternative options might include the broadening the mandate of the existing HDC Consumer Forum; the strengthening the existing DHB system of advisory committees (albeit community care focussed); or the establishment and funding of an appropriate consumer forum by the Ministry of Health.

4.33 If the establishment of a consumer reference group was seen as being both a valuable and cost effective tool to inform policy, it must logically fall to the Ministry of Health as the agency having oversight of the regulatory authorities, to 'own' both the cost and the relationship.

4.34 Council is of the view that it is difficult to see that if the questions raised by this Discussion Paper are addressed by the Ministry's fundamental review of the Act, there is little to be gained from the establishment of one or more consumer reference groups, other than considerable additional cost to borne by practitioners.

5.0 Safety focus

Ministry of Health Statement

> *"The core function of the HPCA Act is to provide a mechanism to regulate occupational groups to ensure that the safety of the public. However, other legislative mechanisms are also concerned with public safety, so it is necessary to consider how the HPCA Act contributes to the overall system of government regulation, and whether the role of professional regulation in safeguarding the public is supported and complemented by the responsibilities of employing organisations.*
>
> *It is therefore necessary to consider whether there is an appropriate balance between the safety concerns of employers and the requirements of government regulation. For example, if employers already have all the systems in place for groups of health professionals to keep the public safe from harm, what additional value does statutory regulation have in this situation?*
>
> ***The Health Practitioners Competence Assurance Act 2003 is one (important) mechanism used to protect the public from harm. "***

5.01 Introductory statement

A greater reliance on employer-based risk management requires considerable caution. It is predicated on a large employer scenario where in fact only a portion of the health workforce is positioned. The majority of oral health practitioners work in a private environment; either for a small employer or they are self-employed. Statutory regulation provides a consistent framework of equal application to all registered health practitioners irrespective of their employment environment and thereby serves to engender public confidence in the competence of practitioners.

The overall quality and safety of services could be improved by addressing the gaps in the relationship and strategic alignment of HWNZ and the education providers.

RAs have managed to develop appropriate thresholds of meaning for "risk of harm" and "serious risk of harm" mindful of the degree of flexibility necessary to respond to evolving professions and nature of risk; these terms do not require statutory definition.

Question 11
Do we currently make the best use of legislation to keep the public safe from harm when accessing health and disability services?

5.02 In terms of outcomes, yes; in terms of the cost to achieve those outcomes, no – significant cost savings could be achieved through a streamlining of the Act and the clothing of RA's with greater discretionary powers – for example section 68(2) which requires RAs to refer any practitioner to a PCC who has been convicted of an offence punishable by three or more months imprisonment. Such a provision catches any conviction for a drink driving offence, no matter how far over the legal limit the practitioner was. PCCs for investigating such offences

cost Council on average $2,500[9] and the cost of legal representation for a practitioner, a similar amount. The usual outcome where it was the practitioner's first offence and the offending was at the low end of the scale offence is an admonishment by the PCC

5.03 There are multiple facets to the health system concerned with protecting the consumer including health and safety legislation and that relating to ACC, and accordingly the ability exists to use legislation other than the Act to address public safety in health. However, it is highly questionable whether the necessary funding and resourcing exists to support the effective use of such legislation.

Question 12

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

5.04 This question is predicated on the assumption that all practitioners are employed by large employers with risk management systems – they are not. The use of employer-based risk management systems as a means of reducing reliance on statutory regulation is viewed as being an extraordinarily high risk strategy.

5.05 To utilise employer based systems risk management to reduce reliance on statutory provisions, by definition first requires that practitioners are in an employment relationship. Eighty-six percent of dentists are self-employed or employed in small businesses. The employer-based risk management systems of large organisations such as District Health Boards or corporates owning dental practices are not utilised by nor are appropriate to the self-employed or to small business. Nor is there a uniformity of risk management strategies employed by District Health Boards or corporates. In addition, differing risk management strategies are applied to different professional groups, for example District Heath Boards credential dentists, but not dental therapists, relying in the latter case upon practitioner audit to identify practitioner or systemic issues.

5.06 It would be possible to use employer-based risk management systems together with employment law to manage competence and discipline issues within a large institutional or corporate employer in substitution for the current statutory regime; however, because such a regime could not apply to those practitioners who were self-employed or employees of small business, a two tier system of regulation would be created. Inevitably an inequality of regulation must result.

5.07 Different responses to performance issues whether competence and conduct based must result in a perception of different quality standards of practitioners depending on whether they work in the public or private sectors. There are already disturbing examples of some large institutional employers 'resolving' competence issues by utilising employment law to terminate a practitioner's employment rather than incur the cost of supporting the practitioner through a competence review and remedial action. Statutory regulation should provide an equitable regime, applicable to all practitioners irrespective of their work setting. Public confidence is engendered in the competence of practitioners through the structure and the consistency of regulation of all registered health practitioners.

[9] PCC costs range from $2,000 to in excess of $50,000 depending on the nature of the offence and the complexity of the PCCs investigation

Question 13

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

5.08 This is an issue more concerned about addressing relationships than about the Act itself. An example of such an improvement was the move by ACC away from the medical misadventure route to a treatment injury regime. Previously ACC claims were identified either as medical mishap (no fault) or medical error. In the case of the latter there developed a reluctance to report medical misadventure because of the risk of a practitioner being found to be at fault and referred to the relevant RA for consideration. This change has meant that the focus is no longer on finding fault with the treatment provided by the practitioner, but on injury itself. By adopting such an approach, ACC has removed the confrontational aspect of its assessment, whilst retaining the ability to refer practitioners to their RAs where a pattern of treatment injury becomes apparent.

5.09. Council is of the view that there are no significant gaps or overlaps in legislation that could be addressed to improve the overall quality and safety of services. There do, however, appear to be gaps in the relationship and the strategic alignment of HWNZ and the education providers, there being no apparent commonality of purpose to provide courses of education and training geared to meet future workforce service delivery requirements.

Question 14

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

5.10 This is a question that raises two fundamental, but quite different issues. First is the issue of whether the inherent risk of harm posed by the practice of each of the professions regulated under the Act is comparable, and if not, are some subject to 'over regulation'? And secondly, should the Act define what is meant by the phrases "risk of harm"[10] and "risk of serious harm"[11]?

5.11 Whether each of the professions regulated by the Act presents the same or a similar risk of harm to the public is a moot point. Certainly the practice of a dental speciality such as Oral and Maxillofacial surgery carries a risk of a greater degree of harm being suffered by a consumer, than does that associated with the practice of dental technology. In the former case, complex, often irreversible procedures are routinely performed, the consequences of which if errors occur could potentially be life changing if not life threatening. By contrast, the practice of dental technology is largely focused upon the manufacture of dental and oral prosthetics to prescription. Where mistakes are made in dental technology practice, the consequences would be likely to be very significantly less traumatic and threatening, than in those suffered by a patient of an Oral and Maxillofacial Surgeon.

[10] Section 35, Health Practitioners Competence Assurance Act, 2003

[11] Section 39, Health Practitioners Competence Assurance Act, 2003

5.12 This begs the question of whether Oral and Maxillofacial Surgeons and Dental Technicians should be subject to the same level of risk regulation – i.e. is the same level of regulation necessary for all regulated professions?

5.13 It can be argued that because the phrases "risk of harm" and "risk of serious harm" are not defined by the Act, RAs have the ability through policy to define them by reference to particular professions and accordingly have profession specific thresholds. Alternatively it can be argued, that if the risk of harm posed by a particular profession to the public is minimal, then the cost of regulation outweighs the benefits and either the profession should cease to be regulated or a lesser degree of regulation, more commensurate with the level of risk, be adopted.

5.14 Whilst regulation does promote the maintenance of uniform minimum standards and affords title protection, this can be achieved at far less cost than is currently the case. Where a profession does not undertake restricted activities, the risk of harm or serious harm to members of the public is correspondingly diminished and it would be entirely appropriate if the impact of regulation upon them was correspondingly lighter. Is annual recertification or a competence regime necessary for all professions?

5.15 The second issue raised by Question 14, is whether the Act should define the terms "risk of harm" and "serious risk of harm"? It is the view of the Dental Council that neither of these terms requires statutory definition.

5.16 RAs have developed and adopted clear and concise policies defining both "risk of harm" and "serious risk of harm" which have proved to be practical, easy to understand and appropriate to the regulated professions. It is entirely appropriate in framework legislation that the definition of such terms are left to individual RAs policy, providing the flexibility necessary to cope with the evolution of the professions, and permitting different thresholds for different professions, calculated by reference to the perceived level of risk. RAs are conscious that the level of risk requiring regulation has evolved since the implementation of the Act and will likely continue to evolve. Enshrining definitions of "harm" and "serious harm" in the Act would prohibit RAs from recognising and appropriately managing the evolving nature of risk.

Question 15

Do you have any suggestions on how those in sole practice can better manage risk related to their clinical practice?

5.17 It is the experience of the Dental Council that those practitioners at greatest risk are those practising in isolation. This does not necessarily mean they are sole practitioners, but identifies older practitioners and practitioners who are professionally isolated from their peers, as being potentially high risk.

5.18 As an integral part of Council's Continuing Professional Development ("CPD") programme established for all practitioners under section 43 of the Act, Council requires each practitioner to complete a prescribed number of Peer Contact

activities during each CPD cycle. Peer contact activities have been defined by Council as:[12]

> "…interactive contact with peers with the specific objective of professional development. The activities should be outcome-oriented and promote reflective practice. Depending on the nature of the activity, **peer contact activities can be verifiable** if they meet the criteria in paragraph 6 above. Peer contact activities are not restricted to practitioners in the same scope of practice. Examples of peer group activities include:
>
> - participation in study groups (*see Appendix 2 for guidelines on setting up a study group*)
> - hands-on clinical courses
> - professional association branch meetings where peer interaction and collective
>
> participation comprises part of, or the entire, meeting
> - attendance at in-service training formal presentations, lectures and conferences where group discussion and/or a question and answer session comprises part of the session
> - peer discussion and review activities within a group dental practice
> - joint treatment planning/patient management sessions
> - practice appraisal including clinical audit and peer review activities
> - providing or receiving mentoring or supervision."

5.19 All practitioners are required to meet their CPD obligations, including Peer Contact Activities by the end of each four year cycle.

5.20 The objective of the Peer Contact activities concept is to ensure that those practitioners who may be professionally isolated develop some interactive professional contact with others of their profession. In order to facilitate regular and ongoing peer contact Council's *Continuing Professional Development Policy* encourages practitioners to establish or to join an established Study Group. Study Groups were conceived not only provide a peer forum for professional development activities, but also serve as network to provide both professional and personal support.

5.21 There is an increasing trend both internationally and now in New Zealand for RAs to conduct clinical audits of a percentage of its practitioners each year, with the objective of having audited all of them over a specified period.

5.22 Currently the Dental Council randomly selects 10 percent of the practitioners from each of the professions it regulates, to complete a self-audit of their clinical practice. The audit is based upon Council's Codes of Practice – in effect minimum clinical practice standards. Upon receipt and assessment of the completed self-audits, a small number of these practitioners are selected for a practice visit to audit their compliance. Appropriate remedial action is taken where necessary.

5.23 For a variety of reasons, there is considerable practitioner resistance to extending practitioner auditing both in terms of the scope of the audit and number of practitioners to be audited.

5.24 Council established a Working Party comprised of practitioners, educationalists and the Director of Professional Development for the Society of Accountants in

[12] *Policy on Continuing Professional Development* Dental Council , last updated 8 August 2011

the first quarter of 2012, to develop a proposal for Council to consider. The Working Party is yet to report to Council.

5.25 Council considers it would be useful for the Ministry of Health to provide advice upon its expectations of RAs in this regard.

Question 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?

5.26 The Dental Council undertakes risk profiling to a limited degree through an observation of patterns of practitioner behaviour particularly in relation to compliance, consumer complaints and notifications from the HDC. However no formal risk profiling methodology is used. Given the limited number of practitioners involved spread across five professions and the cost of implementing a formal risk profiling methodology, Council is of the opinion that no significant additional benefit would be obtained. Accordingly, Council is of the view that risk profiling should not be statutorily mandated, but remain as an individual RA operational option.

6.0 Cost effectiveness focus

Ministry of Health Statement

> *Safety in health and disability service is a critical element, but it comes at a cost. The more that professions are regulated, the greater the potential for regulation to affect the volume and cost of services available to meet the needs of the public. It is therefore necessary to consider the trade-offs required and whether the balance is appropriate.*
>
> *As part of this discussion there are consideration around which professions need to be regulated, whether a graduated risk-based regulatory regime should be considered, whether there are efficiencies that can be gained by review the regulatory processes, and how the collection of data can contribute to risk management efforts.*
>
> ***The costs and benefits of the regulation of health practitioners need to be kept in balance, and ways explored to reduce costs.***

6.01 Introductory statement

A shared consolidated secretariat across the 16 RAs would improve the cost effectiveness of regulation under the Act. Consolidation of the RAs would result in actual cost savings and other benefits from sharing of services, expertise and resources; on the whole, resulting in a more streamlined system, increased standardisation across all health professionals, better value for money, quality assurance and enhanced consumer protection from harm.

RAs do consider the costs of their actions. Legislating for 'cost-consideration' is unnecessary and would be impractical. The establishment of clear ministerial guidelines and expectations would be more useful for RAs balancing the cost impacts and benefits of their regulatory actions.

In the main, statutory regulation remains the most appropriate way to regulate the health professions. However, there is scope for introducing 'degrees' of regulation for different professions balanced against the perceived risk of harm, and the cost of protecting the public from that risk of harm. Such an undertaking, along with the establishment of a consolidated secretariat for the RAs, would be a means of cost reduction within the risk management framework.

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

6.02 At the very forefront of an RAs business is the balance that must be maintained between complying with its statutory obligations under the Act to protect the health and safety of the public, and the resultant cost to the practitioners it regulates, consumers and to the health system.

6.03 RAs give very serious consideration to the cost impacts of their decisions on a number of levels. First, the very significant cost impact on annual practising fees resulting from capital investment such as IT systems and restructuring proposals;

second, the cost to practitioners of competence reviews; third, the cost to practitioners via the disciplinary levy and to individual practitioners of disciplinary action; and fourthly, the huge cost of litigation which is becoming increasingly commonplace as practitioners and professional associations dispute Council determinations.[13]

6.04 Cost to the practitioner balanced against the forecast benefit to consumers is a key consideration when considering whether or not to require practitioners to bear the cost of any regulatory initiative. Such was the case when Council decided to review its practitioner clinical audit requirements. To ensure that all relevant considerations were taken into account, Council appointed an independent Working Group comprised of practitioners, lay people and educationalists to examine whether change was required; if so, to make a proposal to Council for consideration including a cost benefit analysis of the impact of any such proposal. If the Working Group does bring forward a proposal which is acceptable to Council, it would then go to public consultation, where the cost benefit impact would be subject to further scrutiny.

6.05 The Dental Council is extremely cost conscious and takes its fiduciary duty to practitioners and its statutory responsibility to the public extremely seriously. It has as the Chair of its Audit and Risk Management Committee an independent chartered accountant, a senior partner in an international accounting practice who is a specialist in the not-for-profit sector. It has developed a cost allocation methodology to ensure that the costs incurred[14] in respect of each of the five professions it regulates are separately accounted for by profession, to ensure that no cross-subsidisation can occur; and it employs a risk management framework to identify, track and manage financial, statutory and operational risk.

6.06 Being mindful of the cost of regulation, the Dental Council adopted a leadership role in the development of an initial business case for a shared secretariat, following the publication by the Ministry of Health of its discussion paper "*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"* in February 2011. It has remained at the forefront of that initiative, and as an interim measure, led the relocation of six RAs into shared premises. Not only has this resulted in cost savings to the participating RAs, but to an increasing commitment to share services, expertise and resources.

6.07 As noted in paragraph 5.02, the cost of regulation could be reduced by removing some of the prescriptive provisions of the Act and replacing them with RA discretionary powers[15] and by a streamlining of process.

6.08 There is no provision in the Act, requiring RAs to take into account the cost benefit impact of making any decision, nor in Council's opinion should there be. Enshrining 'cost-consideration' in the Act would create a statutory tension between the obligation to protect the health and safety of the public and the cost of doing so, which would render the practical operation of the Act unmanageable. Whilst RAs are subject to normal financial and reporting requirements, and to audit by the Office of the Auditor General, the Dental Council is acutely aware

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13 Judicial Review proceedings were brought against Council by a professional association over Council's decision to consult on an existing scope of practice. Whilst the proceedings were withdrawn shortly before the scheduled hearing date, very substantial costs were incurred.

14 Including time-costed resource allocation

15 For example section 68(2), Health Practitioners Competence Assurance Act, 2003 – mandatory requirement to refer to PCC

that the health system is operating in a constrained funding environment in which the cost impact of decisions and cost benefits of regulation are under constant scrutiny. If government perceives a need to emphasise a need for RAs to better balance the cost impacts of their decisions and the cost of regulation, it is suggested that greater non-statutory guidance could be effective, for example, a published guideline of ministerial expectations to augment the guidelines published by the Office of the Auditor-General.

Question 18
Should the Act define harm or serious harm?

6.09 This question has been discussed in paragraphs 5.15 and 5.16. It is the view of the Dental Council that neither of these terms requires statutory definition.

6.10 Whilst some greater clarity may be an advantage to consumers Council would be concerned by what it views as an overly prescriptive proposal. The threshold is one that has been carefully balanced by both the HPDT and the Courts and accepted as appropriate. Being policy based definitions, means that if the HPDT or the Courts determine they are no longer appropriate or have failed to keep pace with evolution of practice and procedures, the HPDT or the Courts, not being constrained by statutory definitions, will impose new standards or thresholds.

Question 19
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?

6.11 As was noted in paragraphs 5.01 and 5.11, whether each of the professions regulated by the Act presents the same or a similar risk of harm to the public is a moot point. Certainly the practice of a dental speciality such as Oral and Maxillofacial surgery carries a risk of a greater degree of harm being suffered by a consumer, than does that associated with the practice of dental technology. In the former case, complex, often irreversible procedures are routinely performed; the consequences of errors could be potentially life changing if not life threatening. By contrast, the practice of dental technology is largely focused upon the manufacture of dental and oral prosthetics to prescription. Where mistakes are made in dental technology practice, the consequences are likely to be very significantly less traumatic and threatening, than those suffered by a patient of an Oral and Maxillofacial Surgeon.

6.12 This begs the question of whether Oral and Maxillofacial Surgeons and Dental Technicians should be subject to same level of risk regulation – i.e. is the same level of regulation necessary for all regulated professions?

6.13 The Dental Council is of the view that the same level of regulation is not necessary, nor when cost is considered, desirable for all regulated professions. The level of regulation should be commensurate with the perceived risk; and balanced against the cost of protecting the health and safety of consumers from that risk.

6.14 As set out in Appendix 4 of the *Discussion Document*, a number of options are available to provide an appropriate level of protection to consumers, whilst imposing less burdensome and costly compliance obligations on the appropriate professions. It would be appropriate for two tier regulation to be considered – the current licensure regime for those professions undertaking restricted activities; and a less onerous and costly regime for those professions which do not.

Question 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?

6.15 The Dental Council is of the view that subject to its comments in paragraphs 6.11 - 6.14, the options currently available to and being applied by RAs to manage the risk of harm that the different health professions may pose to the public, are both appropriate and largely effective.

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

6.16 The primary barrier to the improvement of RA efficiency is cost. The prime driver of the cost of health practitioner regulation in New Zealand is that the practitioner base of each profession is comparatively small. Because the cost of regulation per practitioner is directly proportional to the number of registered practitioners of a profession, the smaller the number, the greater the individual cost. In addition, the individual cost per practitioner is increased proportionately by such considerations as the complexity of the profession, the number of scopes of practice to be administered, the breadth and complexity of recertification requirements, and the number of practitioner health issues, competence reviews and disciplinary cases to be managed.

6.17 As a consequence of the high cost of regulation per practitioner and the constraints dictated by the need to reduce the cost of regulation, the greater majority of RAs are severely under resourced. In short, because of such low registrant numbers, most RAs cannot aspire to achieve the critical mass necessary to afford the resources necessary to fully and efficiently carry out their statutory functions whilst reducing the cost of regulation.

6.18 Currently 22 health professions are regulated under the Act by 16 RAs, each of which has the same statutory functions and processes. Each RA has 'back-office' functions and operates an IT system and data base to support its functions.

6.19 The administration of RA functions could very significantly be improved and the cost of regulation substantially reduced by the amalgamation of the 16 RA secretariats and the adoption of a single IT system and database.

6.20 If, however the breadth of RA regulatory delivery is to be enlarged by, for example, a requirement to establish and fund consumer forums, or a statutory requirement to provide practitioner pastoral care, the forecast cost saving from a consolidated secretariat would necessarily reduce. Any additional costs incurred by RAs would fundamentally change the underlying assumptions upon which the business model to support proposed amalgamation of RA secretariats was based.

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

6.21 The Dental Council consults on fees, scopes of practice and codes of practice. Each consultation has a significant cost which impacts upon the relevant profession. When consulting, Council sends consultation documents to all relevant stakeholders, including practitioners, professional associations, the Ministry of Health, other RAs, the Australian Dental Council, the Dental Board of Australia, accrediting bodies in New Zealand and Australia, universities, and any other stakeholders identified as having an interest. In addition consultation documents are posted on Council's website and available to the public, who are invited to comment.

6.22 During the year ended 31 March 2012, Council undertook 9 public consultations at an average cost of approximately $5,000 per consultation, excluding secretariat staff costs.

6.23 In addition to consultation, both fees and scopes of practice must be gazetted, and accordingly are subject to scrutiny by the Regulations Review Committee of Parliament as 'deemed regulations' under the Regulations (Disallowance) Act 1989.

6.24 The Dental Council considers that it consults broadly with all relevant stakeholders. The suggestion that Consumer Reference Groups be established to better inform and involve the public in decision making was discussed in paragraphs 4.27 – 4.34. It was concluded there was little to be gained from the establishment of one or more consumer reference groups, other than considerable additional cost to be borne by practitioners

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

6.25 The Dental Council regulates five distinct professions under the Act, and has at least one member of each sitting as a Council member. Whilst each is a separate and distinct profession, they are all oral health professions, providing a continuum within the oral health 'team' environment. They provide complementary and overlapping services and the greater proportion of them are employed in the private sector. Accordingly it appropriate that their regulation is administered by a common body.

6.26. The Dental Council does not feel it is appropriate to comment on what should or should not happen with individual RAs, other than to note that it has in paragraphs 6.06, 6.16 – 6.20 made its position on the proposal to amalgamate all RAs quite clear.

Question 24
What is the ideal size of RA boards?

6.27 This question has been largely addressed in paragraphs 4.21 – 4.26.

6.28 When created by the Act in 2003, the Dental Council was comprised of 14 Council members administering 5 professions. Since inception Council member numbers have, with the agreement of the Minister of Health been reduced to 10, comprised of seven practitioner members (at least one of whom is an educationalist) drawn from each of the five regulated professions, and three lay members. Council is of the view, that this is the optimum size for the Dental Council to regulate 4,500 registrants from 5 professions, encompassing 20 scopes of practice.

6.29 Unlike a number of other jurisdictions, RA Boards in New Zealand are of necessity required not only to discharge their governance function, but to spend significant time making decisions about individual applicants, registrants and practitioners. The volume and complexity of that 'operational' component of a Boards business will have a direct bearing on the number of practitioner members required.

6.30 The optimum size of an RA Board is the product of a number of factors, including the number of the practitioner members needed to efficiently transact the volume of 'operational' business before it; the appropriate number of lay members to at least fulfil the statutory criteria; the expertise and experience of each of the Board members, both clinical and lay; and, the volume of governance business that the Board is required to address. The answer will differ from RA to RA.

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

6.31 The Dental Council, in concert with other RAs, is acutely aware that the health sector is operating under severe funding constraints; that RAs have been exhorted by the Minister of Health to reduce the cost of regulation, and that RAs are resource constrained.

6.32 The amalgamation of RAs appears imminent and will not only involve significant expenditure to implement, but very significant change for RA staff.

6.33 The implementation and bedding down of the Act took some three to four years to achieve, and has been followed by a continuous process of evolution and improvement in a resource and cost constrained environment.

6.34 Council accordingly urges the Ministry of Health to very carefully consider how much change RAs can realistically absorb and manage in the short to medium term future and, the impact of any proposed change on the cost of regulation. If the cost of regulation is to be increased and/or the level of change is significant, there is not only a risk that RAs may have difficulty meeting their obligations, but also a risk of a loss of public confidence. Accordingly, if change is required, Council would prefer it to be in the form of incremental improvement.

Conclusion

The Dental Council thanks the Ministry of Health for the opportunity to participate in the consultation process on the 2012 fundamental review of the Act. Council is happy to answer any queries the Ministry may have about its submission. Queries should be directed to the Registrar, Mark Rodgers, who can be contacted at:

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