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Te Ao Māramatanga
New Zealand College of Mental Health Nurses Inc.
Partnership, Voice, Excellence in Mental Health Nursing

PO Box 77-080, Mt Albert, Auckland, 1350, New Zealand

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Workforce Regulation
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Introduction

Te Ao Māramatanga (New Zealand College of Mental Health Nurses) welcomes this opportunity to provide a submission about the proposed review of regulation of health professions in New Zealand. It is the view of Te Ao Māramatanga that health professions are well regulated and the regulatory bodies have sound processes in place for involvement of the public in regulatory matters. We have concerns that any move to increase public involvement should not be at the expense of the core function of regulatory bodies to ensure the safety of the public, confidence in health services, and best outcomes for consumers. Regulators need to ensure that the competency standards remain contemporary, evidence-based and thus link to the healthcare system. We are concerned at any move to use regulatory processes to advance government fiscal targets as that is not something that is an ethical focus for a regulatory body. We question whether the processes of professional regulation are currently impeding access to health services as no evidence has been provided that this is the case. Access to services is more likely to be responsive to funding of services, or indeed an employment freeze, than to the regulatory context.

Prior to responding to the questions posed, there are number of matters to be noted in responding to the document as a whole:

i/ The document incorrectly states that "Under the HPCA Act 18 regulators have been established to regulate certain health professions": At the outset 13 regulatory bodies were in existence prior to the development and implementation of the Act

ii/ In response to the following on page 3:

So far, we have engaged with key stakeholders including the 18 regulatory authorities, professional associations, Māori professional associations, the Hauora Taiwhenua Rural Health Network, self- regulating professions, the Council of Medical Colleges, and unions.

Note, Te Ao Māramatanga, being the professional association of Mental Health, Addiction, and Disability nurses, was not consulted prior to this publication. This oversight is unfortunate, and so we are responding to this invitation in our professional capacity, not our capacity as members of the NZ public.

iii/ In response to Scenario D on page 8:

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> *My friend, who trained as a specialist in New Zealand and has been practising overseas, is returning to work in New Zealand. However, they have been told they need to complete a course on cultural requirements. I don't understand why this is necessary.*

Note - Whether intentional or unintentional, this scenario shows a fundamental misunderstanding of the process of registration, which is about ensuring safe practice to "first do no harm" and meet the health needs of New Zealanders. Safe practice is not limited to clinical safety, it includes psychological safety, spiritual safety and a host of others, including cultural safety. Safety has been a fundamental tenet of nursing since the time of Florence Nightingale.

Kawa Whakaruruhau (Cultural safety) as first developed by Irihapeti Ramsden, RN, PhD, ONZM and has been a central part of Nursing in New Zealand since the mid-1980s and formally incorporated into the NZ nursing curriculum from 1992. Three years later, the International Council of Nurses recommended its adoption globally. Forty years on, cultural frameworks such as Te Whare Tapa Whā are integral to the delivery of health care, both here and overseas. The hypothetical question posed above is at best disingenuous and at worst intentionally misleading. Health professionals need to be able to respond appropriately to the safety needs of those they serve.

iv/ In respect to the paragraph on page 9:

> *In some cases, regulatory requirements differ significantly between jurisdictions. For example, Bachelor of Nursing students in New Zealand must complete a minimum of 1,000 hours of clinical experience, compared to just 800 hours in Australia.*

The New Zealand situation is substantially different to that in Australia. In New Zealand, we expect every nurse to be a leader of healthcare. Non-registered staff are a longstanding and valued part of the health care team in New Zealand. Australia has had less use for unregulated health care workers historically and in 2019 proposed registration of the same. *Australia also trains twice as many nurses per capita as New Zealand does*, with nurses accordingly having available a longer period of supervision post registration to develop their leadership and clinical skills.

If New Zealand continues to make changes to the health workforce with the introduction of new non-registered health worker roles, then the increase in complexity of the workplace will require professional leadership and supervision, by the nursing profession: This will detract from the public having the most skilled staff available to them. An additional 200 hours in training seems like a reasonable price to pay to enable that expanded workforce, who in many cases bring valuable life experience and skills to health, and some go on to professional

training. Moreover, the Nursing Council has only just completed a review in this regard and hence has maintained that 1000 hours would stay for the reasons identified.

The public health system (Te Whatu Ora) is the largest employer in the country and has one of the most complex matrixed organisations. As has been seen in the past, heavy handed, frequent and clumsy change processes by those who do not understand this complexity substantially damages its capacity to deliver health care to New Zealander's and its ability to attract both locally trained and foreign health professionals. Government direction to registration bodies which has the tone of political or economic ideology behind it will not end well, in an international marketplace where Australia alone could absorb most of the New Zealand registered health workforce and still be experiencing shortages and challenges in some professions. We urge you to tread lightly.

Would you be interested in having a say on any of the following?

a/ Changes to scopes of practice (what health practitioners can do) and how this affects patient care? – There is an assumption that the public know and understand the scopes of nursing practice i.e Enrolled and Registered Nurses, Registered Nurse Prescribers and Nurse Practitioners. This is of concern as the knowledge as to the corresponding ethical responsibilities and codes of conduct that underpin these scopes is understood.

b/ Qualification requirements – Based on international benchmarking, population health, alignment with national and international conventions and guidelines (to which New Zealand has agreed); to have a say, the public needs to understand these and the aforementioned elements identified above.

c/ Other professional standards (for example codes of conduct) that impact patient experience? – Professional standards and not only internal to a RA. The HPCA Act (2003) came about to ensure the registered health disciplines were brought together under a common legislation given the number of existing laws and codes by which some or all must practice. Health and Disability Commissioner's Code of Rights (1996 – and subsequent reviews), in effect, exemplifies and informs what is expected of every health professional and is reflected in the Nursing Council Code of Conduct.

Are there things that you think regulators should consult the public on?

Yes there are areas that regulators must consult the public about.

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Mental health nursing in New Zealand is currently regulated by means of the Health Practitioners Competence Assurance Act 2003 (HPCA Act) which has a strong focus on public safety and patient-centred care. For nurses, the requirements of the HPCA is administered by The Nursing Council of New Zealand which ensures that all registered practitioners are competent and fit to practise. There is currently provision for public participation in this regulatory body. The Nursing Council also engages with Te Ao Māramatanga (the New Zealand College of Mental Health Nurses) a professional organisation that maintains consultation with consumer groups and with the public. The College would be concerned if members of the public were asked to provide advice on areas of health delivery that were beyond their expertise: This particularly applies to issues such as the scope of practice of nursing.

Are there any health practitioners who are currently unregulated but should be subject to regulation to ensure clinical safety and access to timely, quality care. HP who are currently unregulated but should be subject to regulation

No. As nurses are working with health care assistants/psychiatric assistants and have guidance around direction and delegation in place.

Do you think regulators should do more to consider patient needs when making decisions?

As reflected below – this is fundamental and currently underpins all decisions undertaken by the Nursing Council of New Zealand

What are some ways regulators could better focus on patient needs

Regulators already focus on consumer/patient needs for safe care and services. The current process of setting scopes of practice, education standards and standards of competence, as well as having in place robust continuing competency and disciplinary processes are solely predicated around the needs of patients for safe, quality care.

The suggestion that regulators should also address broader systemic issues such as service access, wait times, and workforce availability confuses the role of regulators with that of funders and service providers. These systemic issues fall under the purview of Te Whatu Ora Health New Zealand, the Ministry of Health, and people employed to plan and fund health services. Broadening the scope of regulators to include these elements risks, undermining their core focus; safeguarding public safety through rigorous professional oversight and is likely to result in the unintended consequence of reducing patient safety by confusing the role of the regulator with the role of service providers creating an environment in which it is unclear who is responsible and accountable for what.

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What perspectives, experiences and skills do you think should be represented by the regulators to ensure patient voices are heard?

Regulators already have in place systems and processes to ensure patient voices are heard. This exists through lay person/consumer membership on Boards and through engagement with the profession who are both members of the public and at the coal face of patient interaction. However, there is always a place for the patient voice to continue to inform regulatory practice. Patient stories of their experiences, both positive and negative, are a powerful driver for change. Often these stories (both positive and negative) become visible through multiple channels including the media, family members and investigative processes by the regulatory body or other group such as the Health and Disability Commissioner - Te Toihau Hauora, Hauātanga and Te Tāhū Hauora Health Quality & Safety Commission. There may be opportunity for more formal inclusion of patient voice in regulatory function, potentially through consumer advisory councils or consumer involvement in disciplinary processes where this is not already happening. Strengthening engagement with marginalised communities, rural populations, and those with lived experience of healthcare should be prioritised, but this does not necessitate expanding regulatory mandates.

Healthcare professionals are also natural advocates for their patients and should be considered an excellent source of information on patient needs, experiences, and opportunities for quality improvement. In addition, trained and properly supported and resourced consumer advisors or patient partners can provide valuable lived-experience feedback, input and insights.

In seeking feedback, it is important regulators have access to views that represent the diverse nature of the population of Aotearoa.

Do you agree that regulators should focus on factors beyond clinical safety, for example mandating cultural requirements, or should regulators focus solely on ensuring that the most qualified professional is providing care for the patient?

To be clinically safe, health care must be culturally safe. Current requirements for cultural safety support safe and professional clinical practice, and a culturally safe practice environment for all staff. The most qualified professional is one who has a grounding in awareness of the implications of Te Tiriti o Waitangi for health of all New Zealanders, and of how to maintain professional practice that is both safe from the perspective of their own cultures and the culture of patients they are caring for. To repeat, cultural safety is clinical safety.

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Do you think regulators should be required to consider the impact of their decisions on competition and patient access when setting standards and requirements?

It is our view that it is not the role of the regulator to promote competition in access to health care. The role of the regulator is to ensure that all people accessing health care receive services of an appropriate standard. We would be concerned at any change to the regulatory environment that sought to improve access to services by reducing standards for education or registration, especially if that was aimed at addressing workforce issues by reducing standards for professional registration. We believe such a change would undermine public confidence in health services, (particularly post pandemic) and impact on reputable access to healthcare – the very thing this proposal seeks to improve.

How important is it to you that health professions are regulated by separate regulators, given the potential for inefficiency, higher costs, and duplication of tasks?

This question asks you to select an option on a sliding scale from Very important to Not important. The question then asks you to describe why you have selected what you have with a free text box for comment. Te Ao Māramatanga notes that it is very important that separation is maintained but also make the following points:

- Health regulators have already taken proactive steps to reduce costs and administrative duplication. Several, including the Nursing Council New Zealand, already share services such as IT systems, legal advice, and meeting infrastructure with other regulators. These efficiencies have been developed without compromising professional independence or sector-specific expertise.
- The consultation document lacks empirical evidence to support claims that current arrangements are inefficient. Disrupting current structures without a clear, evidence-based rationale could fragment regulatory functions, create confusion among practitioners, and ultimately compromise patient safety. The link between how streamlining processes will improve the way health professionals work together more seamlessly is also unclear. There is no evidence that this is the case. As per the point above, streamlining some processes like IT systems may be prudent and appropriate in some carefully considered cases, and result in some cost savings and better collaboration between RAs, but it does not necessarily result in health professionals working together more seamlessly. This occurs at the practice interface.

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To help improve efficiency and reduce unnecessary costs, would you support combining some regulators?

This question asks for a yes/no answer with a box for comments. Te Ao Māramatanga will be answering yes with the following comments:

Streamlining efforts should build on existing collaborative models while preserving each regulator's autonomy to make informed, profession-specific decisions. How Regulatory Authorities such as the Nursing Council work to support to other smaller Regulatory Authorities could be used as a model of success and potentially applied to other groups. As an experienced and cost-effective regulator of over 85,000 nurses, the Nursing Council has established shared services to 10 other co-located Regulatory Authorities. The Nursing Council also provides full regulatory services, including employing the Registrar, for the Osteopathic Council. The Council initiated both the Paramedic and Chinese Medicine Councils and understand the cost and implementation considerations involved in the establishment of new structures. Current arrangements enable the Nursing Council to be flexible, agile, and responsive to the government of the day without bureaucratic delays. With nursing being the largest health workforce, the Nursing Council are well positioned to respond to workforce issues while maintaining focus on the safety of the public.

However, it is essential that traditional, hierarchical structures across professions are not perpetuated by combining regulatory bodies. There is a risk that some professions will, either overtly or inadvertently, limit the activities of others if they are combined. There is sense in combining some smaller and aligned regulatory bodies but combining medicine and nursing, for example, would result in poor outcomes for the health system. Medical Colleges in particular, still retain traditional ways of working in a hierarchical system that subjugates nursing (and other professions) both consciously and unconsciously. This type of regulatory body combination would limit innovation and development of new models of care, ultimately resulting in greater costs to the health system and compromising patient safety.

While administrative cooperation among regulators is beneficial, merging distinct professional councils would likely erode specialist knowledge and reduce responsiveness. Nursing, medicine, physiotherapy, and other disciplines each carry unique scopes of practice, ethical considerations, and educational pathways.

The independence of profession-specific regulators ensures decisions are made with deep understanding of the context, evidence base, and risks inherent to each field. A combined regulatory model may also reduce the profession's identity, sense of ownership and engagement with their standards.

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Do you agree that these regulatory options should be available in addition to the current registration system?

Accreditation- Yes

Credentialling - Yes

Certification - Yes

In principle yes, these options should be made available. However any decision to implement any form of regulation should only be made in consultation with the relevant professional bodies. Te Ao Māramatanga would be willing to engage in consultation about any regulatory option relevant to the mental health and addiction sector.

Do you think New Zealand's regulatory requirements for health workforce training, such as the requirement for nursing students to complete 1,000 hours of clinical experience compared to 800 hours in Australia, should be reviewed to ensure they are proportionate and do not create unnecessary barriers to workforce entry? No

In relation to nursing the number of hours in registration programmes has recently been reviewed by the Nursing Council of New Zealand, and reduced from 1100 to 800 hours. It is simplistic to make a comparison with Australia without considering other factors relevant to the number of hours of clinical experience. Many of those calling for regulatory reform have emphasised that Nursing is a practice discipline that requires many clinical hours. Our members are also supportive of more rather than less hours of clinical experience

Should the Government be able to challenge a regulator's decision if it believes the decision goes beyond protecting patient health and safety, and instead creates strain on the healthcare system by limiting the workforce? No

This is a vague question and is almost impossible to answer as worded. What are the limitations suggested? What decisions are under consideration? The Government is always able to question a regulator and discuss issues such as processes of registration, education standards and other matters. However it would not be helpful for public confidence or public safety decisions about individuals were to be challenged by the Government, or if the

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Government were to unreasonably intrude into the functions of regulators as this would limit regulators' independence.

Do you support the creation of an occupations tribunal to review and ensure the registration of overseas-trained practitioners from countries with similar or higher standards than New Zealand, in order to strengthen our health workforce and deliver timely, quality healthcare? Yes

In the case of Nursing there are already processes to ensure that overseas applicants for registration meet the standards of competence for practice in New Zealand. In some cases registration is granted on the basis of understanding of the standards applied in other countries, such as Australia. In other cases individuals are required to demonstrate competence to the standards that apply in New Zealand. An occupations tribunal should be considered as a replacement for the work of the Nursing Council of New Zealand in ensuring achievement of minimum standards and protecting public safety.

Should the process for competency assessments, such as the Competence Assessment Programme (CAP) for nurses, be streamlined to ensure it is proportionate to the level of competency required, allowing experienced professionals who have been out of practice for a certain period to re-enter the workforce more efficiently, while still maintaining clinical safety and quality of care? No

In relation to Nursing this question reflects a lack of understanding of the sector. Changes were made to replace CAP with OSCE assessment. This change occurred in 2023. See https://nursingcouncil.org.nz/Public/NCNZ/News-section/news-item/2023/9/Nursing_Council_changes_to_competence_assessment.aspx

Do you believe there should be additional pathways for the health workforce to start working in New Zealand? No

No, there are sufficient pathways already.

Do you think regulators should consider how their decisions impact the availability of services and the wider healthcare system, ensuring patient needs are met?

This question asks for a yes/no answer with a comment box. Te Ao Māramatanga will be answering no with the following comments:

Regulators do not decide on the availability of health services or the structure and planning required to create and maintain a healthcare system. Impact on the wider health care service and the availability of services is one of the factors regulators consider. Regulators

independently ensure that people have the qualifications and expertise to provide safe care within a system that is designed by planners and employers, and guided by evidence-based policy. Regulators ensure health practitioners have the knowledge and skill within their scope of practice to ensure identified population needs are met. Ensuring patient's needs are met involves many other considerations, not least the investment in a sustainable and fit for purpose public health system, something which has arguably been lacking for many years. We refer for example to Minister Simeon Brown's reported comments on the health infrastructure fund, or the scale of the IT investment needed to deliver the tools that health professionals need to do their work *productively.* Regulators are not responsible for staffing levels or service distribution. These matters are determined by health system funding, workforce strategies, and employer practices. Blaming regulation for shortages or wait times misplaces accountability.

Maintaining high professional standards protects patients and the credibility of the health system. Lowering these standards to address workforce gaps would be counterproductive and potentially dangerous. Regulators have demonstrated flexibility and responsiveness over time to meet the needs of the changing health environment. NCNZ, for instance, has updated and expanded scopes of practice, competency frameworks, and codes of conduct to reflect emerging technologies, changing models of care, and evolving patient needs. It also conducts regular consultations to ensure alignment with sector developments.

Future-proofing regulation does not require structural overhaul, but rather continued support for regulatory independence, investment in data infrastructure, and the inclusion of diverse professional and community voices in decision-making.

Do you think the Government should be able to give regulators general direction about regulation?

Professional regulation has largely been kept independent from government 'direction', for good reason. The regulators are discipline specialists who respond to government policy and make representations to government on issues such as scopes of practice, regulations, and related matters. As a profession, we would like to see the independence of regulatory bodies maintained, less they become subject to direct political whim. In our view it is the role of Government role is to set fiscal policy and respond to developments in health practice but not to directly influence regulation. Any changes towards greater direction on regulatory matters should only occur in collaboration with regulatory bodies. Decision making power should not sit with government alone.

Furthermore, health professionals have a considerably greater degree of public trust than politicians, as well as a long established social mandate to be involved intimately in the lives

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of New Zealanders with health concerns. Overriding that trust and mandate should not be something undertaken lightly, and without consultation with the professions involved.

Do you think the Government should, be able to issue directions about how workforce regulators manage their operations for example requiring regulators to establish a shared register to ensure a more efficient and patient focused healthcare system?

No. Directions like this are full of unforeseen consequences. There is a readily available model for shared services amongst regulatory bodies in Australia, being the Australian Health Practitioner Regulation Agency AHPRA. Consider asking the regulatory bodies to look at this and/or other approaches in similar jurisdictions to our own, and invite them to report on ways of improving the regulatory cost burden.

As with other suggested changes any changes towards something like a shared register needs to respect the need for independent regulation. This relates to the previous point about the need for regulators to be free from direct political influence. If there are ways that the operations of regulators could be improved this needs to be negotiated with regulators rather than imposed on them. Potentially there is merit in a conversation between regulators about the option of sharing of enabling functions, however for the government to direct this brings the potential to create an inadequately resourced single body that does not ensure the nuances of discipline specific competence is achieved.

Do you think the Government should have the ability to appoint members to regulatory boards to ensure decisions are made with patients' best interests in mind and that the healthcare workforce is responsive to patient needs?

The government already appoints members to regulatory boards so this would represent no change. In addition, regulatory boards are already charged with serving the interests of the public, so this would also represent no change. Under the Health Practitioners Competence Assurance Act 2003 all regulatory authorities are required to regularly undergo performance reviews overseen by the Ministry of Health. These reviews examine how effectively a given authority is working, particularly in regard to the statutory functions set out in section 118 of the Act. So there is already transparency of the functioning of regulatory bodies. The functions set out in section 118 show the complexity of tasks required to service on a regulatory body and these are considered by the Ministry of Health in making appointments. If the Government wishes to give greater legislative weight to 'patients' best interests, this could easily be achieved by a simple amendment to section 118. In saying that, a review of the existing provisions of section 118 shows that the whole function of regulatory bodies is to consider matters that are in the best interests or patients. If there is an intent to increase the number or proportion of ministerial appointments this change needs a robust justification.

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We have no objection to the government appointing members to the regulatory boards, as long as the boards set the criteria for those additional members themselves, and the appointees are made from a list of their recommendations. Making political appointments to regulatory boards has all the risks associated with the consequences apparent in our response to Q2.

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About Te Ao Māramatanga- New Zealand College of Mental Health Nurses

Te Ao Māramatanga- New Zealand College of Mental Health Nurses is the professional body and voice for Registered Nurses with specialist mental health knowledge and skills in New Zealand. The college was formed in 2004 and we recently celebrated our 20th anniversary. Our growing membership includes several nurses who have been awarded Fellowship or Whetū Kanapa status in recognition of their contribution to mental health nursing. Members include nurse practitioners, registered nurses, enrolled nurses, nurses who hold a mental health and addiction credential, retired nurses, and student nurses. We have nurses with expertise in a range of settings- clinical practice, education, research, workforce development, policy, primary health services, secondary services, district health boards, non-government organisations, cultural services and specialty areas including disability and addiction. Our members are spread in both urban and rural areas nationwide and link into local College branches. Our college includes an addiction nurses branch and a disability nurses branch.

The College Board brings a wealth of knowledge which we draw from to advance the care of people with mental health problems through the expertise and the professionalism of mental health nursing in New Zealand. Our governance structure is internationally recognised for its bi-cultural constitution and ways of working which includes a president and kaiwhakahaere and a Māori caucus that form part of our board.

As Mental Health Nurses we recognise the need for flexibility, adaptability, responsiveness and sensitivity and we can shape our practices to the changing needs of people, family/whānau and communities. The Bill offers opportunities for nurses to demonstrate this and create and lead the changes required.

Closing remarks

In closing we thank you for taking time to read and consider our submission and we look forward to meeting with the Select Committee.

Ngā mihi nui,
Nastassjia Te Huia
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