New Zealand Nurses Organisation

Submission to

Health Workforce New Zealand

On the

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.

15 April 2011

Inquiries to: Marilyn Head
Policy Analyst
NZNO
PO Box 2128, Wellington
Phone: 04 494 6372
Email: marilynh@nzno.org.nz

ABOUT NZNO

The New Zealand Nurses Organisation (NZNO) is the leading professional and industrial organisation for nurses in Aotearoa New Zealand, representing over 46 000 nurses, midwives, students, kaimahi hauora and health workers on a range of employment-related and professional issues. Te Rūnanga o Aotearoa comprises our Māori membership and is the arm through which our Te Tiriti o Waitangi partnership is articulated.

NZNO provides leadership, research and support for professional excellence in nursing, negotiates collective employment agreements on behalf of its members and collaborates with government and other agencies throughout the health sector. Nurses are the largest group of health professionals, comprising half the health workforce.

The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand and are united in their professional and industrial aspirations to achieve a safe, sustainable and accessible system of public health care for all New Zealanders.

INTRODUCTION

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the proposal by Health Workforce New Zealand (HWNZ) for a shared secretariat for the authorities responsible for regulating health practitioners (RAs), and for a reduction in the number of RA board members.
2. NZNO has consulted fully with its members and staff in the preparation of this submission, including professional nursing, industrial, policy, research and legal advisers, Te Runanga, Regional Councils, and members of the Board and all specialist Colleges and Sections.
3. In addition we have discussed this proposal with other nursing organisations, in particular the College of Nurses Aotearoa (CNA), the New Zealand arm of

the Council of Deans of Nursing and Midwifery, Australia and NZ, Te Ao Maramatanga (New Zealand College of Mental Health Nurses) and the Nurse Educators of the Tertiary Sector (NETS), who all fully endorse this submission.

4. We have also consulted with other health practitioner associations and found a marked degree of concordance with a number of them; accordingly, NZNO is a signatory to the joint health practitioner associations' submission.

5. There is a strong consensus about the poor quality of the document, which ignores the RA's primary purpose to protect public safety, and lacks supporting evidence, credible financial analysis or rationale for the proposals.

6. We believe that the outcome of this proposal risks a period of unnecessary disruption to established registration processes which are generally safe and cost effective (no evidence has been presented that suggests otherwise); that it may result in a longer, or less robust, process for registration; and that it is highly unlikely to lead to significant cost savings, and may, in fact, lead to greater costs for the government, health practitioners and employers.

7. We have serious misgivings about the proposal's timeframe and the practicality of meeting a three month objective at that time, (immediately following an election and over the Christmas period) and are not confident that the transition costs, and therefore projected savings, have been fully and accurately analysed.

8. NZNO is particularly concerned that the proposal shifts the responsibility and costs for the collection of health workforce data from the body responsible, the Ministry of Health, to health practitioners, via their annual practice certificate fees.

9. The precedence given to the stated and implied objectives of saving costs and avoiding legislative change conflicts with protecting the integrity and

independence of the regulator under the Health Practitioners Competence Assurance Act 2003 (HPCAA).

10. Similarly the process for restructure is flawed in being undemocratically dependent on the agreement of the RAs only, in order to proceed with the restructure, and in altering the legislated function of the RAs.

11. We believe broad agreement on any proposal to consolidate would be necessary before commenting on the details of the model as per the focus questions.

12. NZNO supports looking at ways to increase collaboration, improve consistency and efficiency, allow for innovation, and standardise health workforce data. Reducing the workforce which processes registrations will not achieve any of these, nor address other identified cost risks such as the proliferation of RAs.

13. While we suggest alternative, more easily managed options for reducing costs, such as moving to a three year practising certificate term, NZNO urges HWNZ to build on the work already done in identifying the transformational change needed in the way the RAs collaborate and function, rather than the fixed costs associated with the administrative processes.

14. NZNO **does not** support the document or any of the proposals therein.

DISCUSSION

15. It is disappointing that the recommendations for improving the performance of RAs identified in the report following the lengthy Review of the Health Practitioners Competence Assurance Act (Ministry of Health, 2009) have been reduced, in the first instance, to this questionable cost-cutting exercise of reducing administrative costs, without regard to the impact on the RAs' primary purpose.

16. Clearly there is no point in effecting 'savings' which result in the RAs not being able to fulfil their purpose of protecting public health, nor in reducing administrative capacity (which is essentially how the cost of the shared secretariat has been calculated), if the result is reduced efficiency in registering practitioners, and in addressing the continuing competence processes required by the HPCAA.

17. There does not appear to be any evidence that the RAs are inefficient, just an assumption that there are economies of scale with consolidation, regardless of the different disciplines involved. Arguably, however, the same number of health practitioners has to be regulated, and it seems more likely that those with experience and knowledge in each discipline will handle the processes involved most efficiently.

18. Certainly NZNO is confident that NCNZ is efficient and cost effective, and we doubt that that there is anything to be gained by consolidation into a single secretariat, except higher registration costs for nurses and employers, including publicly funded bodies such as the District Health Boards (DHBs).

19. Nor is it likely that workforce innovation or cross- and inter-disciplinary collaboration will be driven by a secretariat, rather than by the Councils that lead them. There is little recognition in this document of the potential for improved functionality and innovation, which is where we suggest the real gains in cost-effective health regulation are to be made.

20. The HPCAA Review, for example, indicated that while there may be the potential to reduce costs through shared administrative services, particularly for smaller RAs, the real barrier to consistent, cost effective and safe health workforce regulation was the lack of robust pathways to strong interdisciplinary collaboration between the RAs.

21. The process for efficient regulation should begin with facilitating such collaboration and establishing the function of the RAs and their role in

assuring an integrated, sustainable, high quality health workforce able to meet the health needs of New Zealanders, *before* dictating what administrative resources are needed to support that role.

22. We refer HWNZ to the ability of the RAs to respond swiftly and safely to the urgent need to register health practitioners following the recent Christchurch earthquake as an example of their efficiency and thorough knowledge of their respective professions. It is doubtful that such a response would have been possible with a shared secretariat and fewer employees covering all professions.

Reducing costs

23. The financial analysis is inadequate, particularly what appears to be the assumption that the combined costs of the nursing and medical RAs will account for the combined costs of a secretariat servicing many more authorities, with no acknowledgement of the reduced capacity that must entail.

24. The costs of transition seem seriously underestimated and fragmentary. No consideration appears to have been made for what happens to the assets, for example, or for penalties for termination of software, leases and other contracts, and the costs of redundancies seems optimistically low.

25. NZNO believes there are alternative, far more easily managed options for reducing costs, for example, moving to a three or five year practising certificate for experienced HPs with good records.

26. We note that the costs of regulation were the subject of one of the principles considered in the Ministry of Health's paper *How do we determine if statutory regulation is the most appropriate way to regulate health professions?* and refer you to our submission (NZNO, 2010) which discussed the balance between safety and cost.

27. In particular we suggested that "consideration of the very real risks and wider safety issues posed by the current rapidly-changing health environment .... and understanding of the type of workforce New Zealand needs and can sustain" should be the basis for an holistic approach to the regulation of health professions, anchored in practice.

28. We reiterate here, that it is in *that* context that excellent regulation - efficient, innovative, and safe - must emerge, otherwise there is a high risk that regulation will become less relevant.

29. As an aside, we again note the Ministry of Health's questionable quantitative "analysis" of submissions on that document, where individual submissions were accorded the same weight as collective submissions representing, in NZNO's case, thousands of individuals and a significant section of the workforce; no qualitative analysis was offered according to expertise or experience of the submitter(s).

Shared Workforce Data Collection

30. NZNO is doubtful that shared access to workforce data based on *anticipated* migration of data to a single system is deliverable within the timeframe, or that a shared secretariat is necessary for achieving that important goal.

31. There is a significant risk in relying on projected information technologies (IT) being fully tested and ready for implementation when required. We note that many of these 'unifying' IT projects have failed to live up to expectations and the emphasis is not necessarily on centralisation but rather interoperability.

32. Moreover, it is not the function of RAs to collect workforce data, nor for health practitioners to pay for it. Data collection is not part of the RAs' legislated function.

Process

33. NZNO questions the process outlined for this restructure, which is wholly reliant on the (voluntary) agreement of the RAs ("if agreed with RAs, this proposal will be implemented", page 4).

34. Though we are confident that the Nursing Council of New Zealand (NCNZ) (*Kai Tiaki*, April 2011) and other RAs will reject this proposal, it is not acceptable that the views of those most concerned will not be given equal consideration.

Reduction in Council size

35. NZNO does not support the proposed reduction in Council members, which may result in the loss of technical expertise, may further reduce Māori input which already lacks a compulsory member voice, and is predicated on saving costs and uniformity, rather than reducing the risk of harm.

36. Moreover, it is not clear which members are to be dropped; it would certainly be counterproductive to reverse the relatively recent and welcome decision to include elected members on the Nursing Council. We would be equally reluctant to see a drop in lay membership.

37. The immediate exemption of the Medical and Dentistry Councils from having to conform to a seven member Council is a clear indication that one size will not fit all Councils, though the logic on which it was based – on the number of specialised areas of practice - is strained. We note that the broader compass and significantly larger workforce of nursing is not given the same consideration.

CONCLUSION

38. NZNO again thanks you for this opportunity to contribute to the discussion and **recommends** that you:

- **note** that we **do not** support the proposed modifications to the RAs, based on what appears to be fragmentary and incomplete data, inadequate financial analysis and project planning, and unsubstantiated argument;
- **agree** that the focus for improving the cost effectiveness of health practitioner regulation should be on facilitating RA collaboration and consistency, rather than administrative processes;
- **note** our strong objection to the lack of consideration given in this document to the primary purpose of the RAs, in regard to the impact of the proposals on that function i.e. the risk to public health, and the addition of new, non-legislated functions, such as responsibility for the collection of health workforce data;
- **note** that we believe the process for proceeding on the basis of agreement by the RAs is inherently flawed;
- **note** we **do not** support changes to Council membership without the broad agreement of the sector; and
- **agree** that there are alternative easier ways to reduce costs.

Marilyn Head

Policy Analyst

REFERENCES

Ministry of Health. 2009. Review of the Health Practitioners Competence Assurance Act 2003 - Report to the Minister of Health by the Director-General of Health. Wellington. Ministry of Health

NZNO. 2010. Submission to the Ministry ofHealth on *How do We Determine if Statutory Regulation is the Most Appropriate Way to Regulate health Professions*? Retrieved http://www.nzno.org.nz/Portals/0/Docs/Activities/Submissions/2010-03%20Statutory%20regulation%20of%20health%20professions%20NZNO%20SUB.pdf