Dental Council

Te Kaunihera Tiaki Niho

Submission

on the Draft Report of the Productivity Commission

Mutual Recognition Agreement and the Trans-Tasman Mutual Recognition Arrangement

July 2015

To: the Australian Productivity Commission
LB 2, Collins Street East
Melbourne
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AUSTRALIA

Introduction

The Dental Council ("Council") welcomes the invitation from the Productivity Commission ("Commission") to comment on its Draft Report regarding the *2014 Review of the Mutual Recognition Agreement and the Trans-Tasman Mutual Recognition Arrangement*. Council is also grateful for having had the opportunity to attend the Roundtable held in Wellington on 14 July 2015.

The Recommendations

Council is broad agreement with the recommendations made by the Commissioner. It notes that since the introduction of the Trans-Tasman Mutual Recognition Act ("TTMRA") in 1997, the regulatory framework governing health practitioners has very significantly changed in both New Zealand and in Australia. Accordingly refinements of the existing arrangements, are warranted.

Council does however have concerns about Commission's evident desire move toward the adoption of Automatic Mutual Recognition ('AMR") or at the least, the adoption of some elements of AMR.

AMR

It was apparent from the Roundtable held in Wellington on 14 July 2015 that the Commission has an incomplete understanding of the regulatory framework applicable to health practitioners in New Zealand; of the purpose, structure and operation of the Health Practitioners Competence Assurance Act 2003 ("HPCAA"); and in particular, of the competence regime established by the HPCAA. A full understanding is necessary, before any meaningful dialogue can be entered into on the adoption of AMR or any facets of it.

In December 2004 the HPCAA was implemented in New Zealand and in 2009 - 2010, the Health Practitioner Regulation National Law (the "National Law") was enacted in each of the Australian states and territories. Whilst this has resulted in a much closer alignment between two regulatory regimes and a significantly increased level of cooperation between regulatory authorities in each of the two national jurisdictions, co-regulation in New South Wales and in Queensland appears to have imposed an additional level of regulatory complexity on an already complex and multi-layered regulatory framework.

The New Zealand regulatory framework for registered health practitioners

Regulation of registered health practitioners in New Zealand is undertaken by a triumvirate comprised of 16 Regulatory Authorities governing 21 professions; the Health and Disability Commissioner ("HDC"); and the Health Practitioners Disciplinary Tribunal ("HPDT"). The Dental Council is one of the 16 Regulatory Authorities established and constituted under the HPCAA.

In this multi-layered approach, each of the Dental Council, the HDC and the HPDT have different but complementary roles in regulating registered oral health practitioners. This separation of roles and powers between the three bodies is an important aspect of the New Zealand system of regulation.

New Zealand also has a no-fault compensation scheme administered by the Accident Compensation Corporation (ACC). This scheme also plays a part in establishing the consensual style of regulation.

The HDC is responsible for the initial consideration and investigation of all complaints about registered health practitioners where a patient has been affected; and when appropriate refers them on to the Council. In the event of a finding that registered health practitioner breached the Code of Health and Disability Consumers' Rights, the Commissioner may refer that provider to his independent Director of Proceedings, to decide whether to bring disciplinary proceedings before the HPDT or before the Human Rights Review Tribunal.

The Commissioner weighs the complainant's wishes, the practitioner's submissions and the overall public interest in deciding whether to refer a practitioner found in breach of the Code to the Director of

Proceedings. As a general rule, cases must be considered to be wilful, reckless, unethical or criminal before they are seen as so serious as to warrant referral. The Director then decides whether to issue proceedings taking into account the public interest and the likelihood of success. For registered health professionals the usual avenue is proceedings before the HPDT.

The HDC and Council encourage practitioners to settle most cases through a conciliatory and remedial approach designed to get them back into effective practice as quickly as possible. Although most HDC investigations do result in a finding of breach of the Code of Health and Disability Consumers' Rights, investigations are undertaken in only 10% of complaints. The HDC generally settles most complaints (including many that lead to an investigation and breach finding) through an apology from the practitioner concerned. The HDC will also note changes the practitioner has made in their practice and recommend any further improvements, for example re-education.

Council can initiate immediate action in respect of complaints about the competence of individual practitioners and does not have to await the outcome of the HDC's consideration. Very few clinical negligence complaints are referred to the HPDT either by the HDC or by Council. In most cases considered by Council, under its competence procedures, the practitioner is required to undertake a competence review. Where a practitioner is found to be working below the required standard of competence the usual outcome is for the Council to order the practitioner to undertake a competence programme, usually incorporating a structured educational programme. This may include supervision and some form of retraining. When Council places conditions on a practitioner's scope of practice these will be recorded on the publicly available register. Council, in keeping with the intent of the HPCAA and in concert with all the other health Regulatory Authorities, has a strong focus on practitioner rehabilitation.

The HPDT, which was set up in 2004, adjudicates on final conduct cases of all of the healthcare professional regulatory bodies in New Zealand. It is rare for competence cases to be referred to the HPDT although it does have jurisdiction to hear such cases.

The HPDT can impose the following range of sanctions, which the practitioner can appeal to the High Court:

- Fines
- Conditions
- Suspension
- Cancellation of registration.

In addition, the ACC provides no fault compensation for people who have suffered harm or unintended consequences of medical treatment. ACC does refers cases to the HDC and to Council for further consideration.

The division of roles between the HDC, Council and the HPDT, while providing an effective framework for the management and resolution of concerns about oral health practitioners, also requires a high level of commitment to communication between the organisations. Cases may be referred between the HDC and Council and both may refer to the HPDT. With increasing frequency, the ACC also refers cases to the HDC and Council.

The sometimes separate and sometimes parallel roles of the HDC and Council and their relationship to the HPDT, coupled with the internal independence of the Director of Prosecutions at the HDC and Professional Conduct Committees appointed by Council, create a complicated matrix of procedures, rules, responsibilities and rights.

Council must operate within the New Zealand legislative framework and in accordance with the provisions and statutory intent of the HPCAA. Accordingly its ability to change the way it operates, is very limited without fundamental statutory change.

Health Practitioners Competence Assurance Act 2003

The HPCAA is comprised of 7 Parts:

Part 1 – Preliminary and key provisions

Part 2 - Registration of, and practising certificates for, health practitioners

Part 3 - Competence, fitness to practise, and quality assurance

Part 4 – Complaints and discipline

Part 5 – Appeals

Part 6 – Structures and administration

Part 7 – Miscellaneous provisions, consequential amendments and repeals, and transitional provisions

Part 1 of the HPCAA provides that the principal purpose of the Act is 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]

The key words in this provision are *"ensure*" which places a very high standard on Council; and "…*providing for mechanisms*…" which provides focus for the establishment of standards and the maintenance of competence.

Unlike the Australian Health Practitioner Regulation National Law (the "National Law"), there is no objective or requirement for the facilitation of workforce mobility.

Part 1 of the Act defines a health practitioner to be a person

> "…who is, or is deemed to be, registered with an authority as a practitioner of a particular health profession."[2]

This part of the Act also makes it an offence for a registered practitioner to practice without a current annual practising certificate.

Under Part 1 of the HPCAA Council has set its scopes of practise and the prescribed qualifications for each. In doing so Council has recognised a number of qualification from other jurisdictions including Canada, the United States and the United Kingdom as prescribed qualifications and accordingly, graduates of recognised programmes from those countries are entitled to registration in New Zealand without further examination or assessment. Qualifications from the Republic of Ireland will soon be added to that list.

Part 2 of the HPCAA sets out the requirements for registration and annual practising certificates. In respect of the latter, it establishes the annual recertification requirements that each practitioner must meet in terms of fitness to practice, competence and provides the statutory basis for continuing professional development.

Part 3 of the HPCAA establishes regimes for the maintenance of practitioner competence and the management of practitioner health issues. Both are rehabilitative in nature. The nature of the competence regime, is set out later in this submission.

Part 4 of the HPCAA deals with complaints in discipline. Any complaint received by Council which alleges that the practice or conduct of a practitioner has affected a consumer, must be referred to the HDC. Whilst the matter is being considered by the HDC Council may only initiate competence procedures.

It is important to understand that Council has no disciplinary powers. Where a complaint is referred back to Council by the HDC or the complaint is one that need not be referred to the HDC in the first instance, Council may refer a matter to a Professional Conduct Committee ("PCC") for investigation,

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

[2] Section 5(1) Health Practitioners Competence Assurance Act 2003

which may following its investigation, lay charges against the practitioner before the HPDT. A PCC is an independent committee comprised of 2 peers of the practitioner and a lay or community member, who are appointed by Council to conduct the investigation. Once appointed, the PCC is completely independent of Council other than for funding, and may employ its own Counsel and investigators.

Part 5, 6 and 7 of the HPCAA are not relevant to this submission.

The competence regime

The competence regime established under Part 3 of the HPCAA is unique. Unlike any other jurisdiction, matters of practitioner competence are not dealt with as disciplinary matters, and are not punitive, being remedial and rehabilitative in nature. No charges are laid, nor does the Regulatory Authority seek to establish practitioner guilt or fault. The process is designed to review, remediate and educate.

Because charges are not laid, when Council determines that a practitioner's competence may be deficient and implements a competence programme to educate and remediate, the practitioner concerned has no legal right of defence or ability to dispute Council's decision beyond judicially reviewing the efficacy of Council's decision. Accordingly, and because allegations of a competence deficiency have the ability to very significantly impact a practitioner's reputation and income earning capability, the normal rules of regulatory transparency and disclosure are suspended. If the allegation is a consequence of a patient complaint, details of the outcome of the competence review and resultant competence programme generally remain confidential to Council and the practitioner. The only exception to this general rule could be disclosure that a formal order of Council had been made and the appearance of any condition placed on the practitioner's scope of practise, on the public Register.

Currently disclosure by Council to the Dental Board of Australia of the detail of practitioner competence issues (and health concerns) presents an issue when the practitioner is registered in both jurisdictions. Whilst the Commission noted that section 19(2)(i) of the TTMRA provided a catch-all for the making of inquiries and the exchange of information by Regulatory Authorities, unfortunately, this provision is limited to the registration application and registration process only. It does not provide authority for a New Zealand Regulatory Authority releasing information to its Australian counterpart, after the fact of registration.

Council set out is some detail the nature of the competence regime in its submission of February 2015.

Funding model

Mention was made by the Commission of the potential cost benefits to individual practitioners that could result from AMR. It noted that without a requirement to register locally, the capacity of Regulatory Authorities to protect consumers would be undermined because they depended on registration fees to fund enforcement activities. It was suggested that losses in revenue could be handled through changes to funding models, because any losses would be unlikely to outweigh the wider benefits.

Council is funded by the practitioners through annual practising certificate fees and disciplinary levies. Registration fees and other fees charged, whether to practitioners, candidates for registration or any third parties are charged on the user pays principal and strictly calculated on a cost recovery basis. Annual practising certificate fees fund the running costs of Council and those costs incurred which are not recoverable in the competence and health arenas, whilst the annual disciplinary levy funds the cost of PCCs, HPDT and High Court appeals.

Accordingly if Australian registered practitioners were permitted to practice in New Zealand, any costs relating to their doing so would have to be borne by the registered practitioners of New Zealand in their annual practising fees and where appropriate through the annual disciplinary levy. This would

not be acceptable and would in all likelihood be a breach of Council's fiduciary duty to New Zealand registered practitioners.

Conclusion

Council is relatively comfortable with the recommendations the Commission has made.

It is however strongly opposed to the concept of AMR which would require very extensive legislative amendment, which it considers would significantly derogate from the legislative framework and intent and ultimately from the ability of New Zealand Regulatory Authorities to fulfil their statutory purpose of

> "… [protecting] 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."[3] [emphasis added]

From a practical perspective, given the fundamental differences between the New Zealand and Australian regulatory regimes, AMR would be unworkable. Further, to suggest that New Zealand practitioners would be prepared to fund the entry of their Australian brethren into the New Zealand market and fund the costs of any competence or health concerns or disciplinary action taken against them, is unacceptable.

Council would be grateful if the Commission would address the current issues that we have in exchanging information, particularly as it applies to practitioners registered in both jurisdictions.

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