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Tēnā koe Diana

**Response to the proposal to regulate physician associates under the Health Practitioners Competence Assurance Act 2003**

Thank you for the opportunity to submit a response to the proposal that physician associates (PAs) be regulated under the Health Practitioners Competence Assurance Act 2003 (the HPCAA).

**Executive summary**

- The Council's view is that the risk of harm posed by the small number of PAs currently practising in New Zealand is not sufficient to require regulation under the HPCAA.
- The current proposal does not include meaningful analysis of potential disadvantages and costs relative to the potential benefits of regulation under the HPCAA canvassed in the document. This is needed to ensure that present risk is managed at a suitable level and in a fiscally responsible way.
- There are several other ways to manage current risk without pursuing regulation. It would be reassuring to see analysis of these other options to demonstrate that the costly and complex choice to regulate under the HPCAA is the most appropriate option.
- Consistency of qualification and practice is key to public safety. PAs in the United States and Canada are not all subject to regulation, and there is no consistent standard of practice. Regulation under the HPCAA would first require creation of a New Zealand PA training programme and standard of practice, against which to assess the competency of PAs trained overseas. Given the small number of PAs in New Zealand, regulation does not seem a proportionate pursuit at this time.
- Should the context change, this proposal could be revisited in future, for example, if a New Zealand PA training programme is established, or if there is a significant increase in the number of PAs working in New Zealand, as these factors could impact of the level of risk.

**Regulation under the HPCAA**
Right-touch regulation[1] underpins the Council's work. The UK's Professional Standards Authority explains this: 'Right-touch regulation means understanding the problem before jumping to the solution.'[2] 'It means looking at the level of risk to the public and identifying the most proportionate means to counter that risk.' Regulation of any profession should only be considered after non-legislative options are found to be insufficient. Considered through a lens of right-touch regulation, the regulation of PAs under the HPCAA does not seem a proportionate response to the risks identified in this case.

The assessment of risk should be based on PA practice in New Zealand as it is currently, rather than on variable overseas contexts. In New Zealand, PAs are supervised for the duration of their career and so any risk associated with their practice is monitored and managed.

Possible unintended consequences of PA regulation for our existing medical workforce should be considered. Council believes it is unlikely that regulating PAs would ease the pressure on our medical workforce, given the supervision requirements of the role. Regulation of PAs is likely to result in an increased presence of an overseas trained profession that requires induction, orientation and supervision, from a senior clinical workforce that is already under pressure. This in turn, will put further pressure on already limited access to supervision and training opportunities for other clinical trainees.

Establishing regulation of PAs under the HPCAA would be much more complex than it has been for other professions (such as paramedics) as there is no existing training programme in New Zealand. Regulation has not been pursued for a health profession without the foundation of a New Zealand training programme before.

It would be more efficient and cost-effective to first explore existing mechanisms, other than regulation under the HPCAA, that could more proportionately address any risk. This would allow an opportunity to consider any regulatory mechanisms that might be required in future, particularly if there is a significant increase in PA numbers in New Zealand, or if a New Zealand training programme is established.

Issues of cost and funding are also important elements when considering regulation and, in the Council's view, further fiscal advice should be sought. These and other points noted so far are expanded on in this submission.

The Council consulted and engaged widely with the medical profession and key stakeholders to inform this submission. It received 158 responses, including from medical colleges and other responsible authorities (RAs) that are not part of the Ministry of Health's (the Ministry's) consultation. This submission also draws on discussions with the Ministry, and with the New Zealand Physician Associate Society (NZPAS).

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[1] The concept of right-touch regulation is the application of the principles of good regulation identified by the Better Regulation Executive in 2000 (based on findings of the Organisation for Economic Co-operation and Development), to which the Professional Standards Authority added agility as a sixth principle in 2009.
[2] Professional Standards Authority - Right-touch regulation

**Managing current risk**
It would be valuable to gather details about the practice of the 33 PAs currently working in New Zealand including the benefits, challenges, risks and how those are currently mitigated. Also valuable would be a comparison between PAs currently practising in New Zealand, and the Physician Assistant Pilot (or 'demonstration') that took place some years ago across several locations in New Zealand. These insights would help determine the most beneficial and proportionate way to oversee PAs in the context of our health system.

The consultation document suggests that the Health and Disability Commissioner (HDC) has different authority over regulated and non-regulated professions – this is a misconception. The statement that 'the HDC Act can only provide retrospective protection to the public' is true for all health care practice, whether practitioners are regulated under the HPCAA or not.

The document notes that PAs currently working in New Zealand are self-regulated or are subject to employer regulation. The document identifies these as insufficient, but there is detail missing to explain why they are considered insufficient.

In the Council's view, there are other existing models that would mitigate risk appropriately, such as credentialling or licensing. Some employers already have requirements for employees in non-regulated health professions or have a credentialling process in place.

**Financial considerations and conflicts of interest**
Measures necessary to protect public safety should not be constrained or compromised by the potential costs. Nevertheless, to ensure risk is managed in a fiscally responsible way, the Council would be reassured by a cost-benefit analysis of the various options available, as it is costly to regulate a new profession under the HPCAA, and more so given the very small number of PAs. It would be useful to see analytic evidence that investment in regulating PAs is more advantageous than investing in expansion of an existing scope, such as nurse practitioners[3], that the public and other practitioners are already familiar with.

The Council agrees with the Ministry that the impacts of regulation will likely include: 'significant start-up and ongoing operational costs to practitioners and employers,' and 'frequent conflicts of interest within a small profession (for example when the responsible authority sets up committees under the Act)'.

The Council estimates that initial set-up costs to establish regulation of a new profession (without a New Zealand training programme) could reach $500,000.

The Ministry notes that any regulatory impact statement related to this decision will include an estimate of the costs to establish regulation. This suggests that cost is a key part of the decision-making process and therefore it requires greater consideration at an earlier stage. The question remains of whether the value of regulating a new role is greater than developing already regulated roles.

The Ministry has advised the Minister[4] that an estimate of the costs to establish regulation will be developed jointly by the profession and the host RA. As existing RAs are resourced by the

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[3] Nurse practitioners are currently regulated, with existing training programmes in New Zealand.
[4] Manatū Hauora, Briefing: Progressing the application for statutory regulation of the Physician Associate profession, H2023021083

profession(s) they currently regulate, any work towards regulation of PAs would mean using funds provided by one profession to support another. Cross-subsidisation is not appropriate, and a host RA would require external funding for establishment activities.

The Council notes that the NZPAS has indicated financial support to establish regulation; this is also not appropriate as direct funding from a professional association or organisation to a regulator gives rise to actual and perceived conflicts of interest, that have the potential to compromise the independence of the regulator and decision-maker.

The Council recommends that advice on specific funding arrangements is sought from the Office of the Auditor-General.

**A representative workforce**
A workforce representative of the New Zealand population is key in achieving health equity. Increasing the number of internationally trained PAs in the health workforce[5] would further reduce the proportional representation of Māori and Pasifika.

Regulating PAs will not automatically generate a New Zealand-based training programme (as it is not the role of a RA to create this[6]) and as Māori, Pasifika, and other underserved groups are unlikely to have access to the overseas training required to become a PA, it would not be possible to create a representative PA workforce.

Overseas-trained PAs will also require education about New Zealand culture and health care context, and what this means for their practice including the history and implications of Te Tiriti o Waitangi, the principles of cultural safety and the goal of health equity. Consideration should be given to how this will be managed and resourced.

It is widely acknowledged that a long-term solution to the current workforce crisis is to build a sustainable workforce, and sustainability ultimately relies on growing and retaining a 'homegrown' medical workforce. This will take time and will need to be supported by internationally trained health professionals, but the Council does not believe that the regulation of PAs would bolster this.

**Consistency of qualification and practice key to public safety**
It is the Council's view that regulation would not yield consistency or verification of skill, if the United States approach was followed. PAs are not uniformly trained and their day-to-day practice mirrors that of their individual supervisors. Of significance, PAs are not regulated in all states and provinces of the USA and Canada, therefore they are not subject to a consistent standard even across North America.

In reference to the United States the addendum to the consultation document notes, '… the majority of states have abandoned the concept that a medical board or other regulatory agency should make

[5] Our health workforce already relies heavily on international medical graduates, with over 40% of current registered doctors having gained their primary medical qualification abroad.
[6] Without an accredited training programme in New Zealand, there is not a way to determine the transferability of the variable overseas PA qualifications. Regulation would subsequently necessitate the establishment of scope of practice, determination of appropriate qualifications, creation of standards of education and training and assessment standards for practitioners, setting of standards of clinical competence, cultural competence and ethical conduct, and determination of actions to be taken when these are not met. This will take significant time and funding to achieve.

decisions about scope of practice details for individual PAs. Most states allow the details of each PA's scope of practice to be decided at the practice level.' The Ministry's proposal highlights consistency as a key driver, yet the decisions in the United States to eschew the notion of consistency of scope and experience is at odds with this.

The addendum also notes that, 'The NZPAS's Voluntary Register only lists PAs trained in the United States, the United Kingdom, and Canada, noting that the training requirements and certification standards in these three jurisdictions are quite similar.' However, this does not provide sufficient assurance of quality of training and consistency of skill and knowledge. The absence of a New Zealand training programme means that there are no local standards against which to assess the overseas trained PAs' qualifications and training.

The NZPAS has commented that the Council's 'practice guidelines' also offer guidance to PAs. These standards of practice have been developed specifically for doctors. If regulation is pursued, it would not be the case that standards for the medical profession would automatically apply to PAs, given the notable difference in clinical training and expertise; a set of standards specifically for PAs would need to be developed.

**Closing comments**
The Council does not believe that the risk of harm posed by the small number of PAs currently practising in New Zealand warrants regulation under the HPCAA. There are several other ways to manage this risk without pursuing regulation at this time. This proposal can be revisited in future, should the number of PAs practicing in New Zealand increase significantly, or should a New Zealand training programme be established.

The Council does not agree it would be the most suitable RA for PAs, and the Council is available to discuss other options for overseeing PAs.

We would welcome an opportunity to discuss this response with you. We look forward to continuing to work with you in protecting the health and safety of the public and promoting good medical practice.

Naku noa, nā

Joan Simeon
**Manukura | Chief Executive Officer**