Submission to New Zealand Ministry of Health Manatū Hauora

Statutory regulation of the health professions

Review of the basic principles justifying statutory regulation of the health professions

March 2010
Executive Summary

The Australian College of Ambulance Professionals (ACAP) is the national body representing paramedics engaged in the delivery of out of hospital Emergency Medical Services (EMS). ACAP does this through research support; programs of professional development; publication; and other activities designed to enhance the standards of EMS practice and thereby protect the health and safety of the community.

ACAP therefore has a particular interest in the regulation of health professions in both Australia and New Zealand, given their close economic and cultural ties and the Trans-Tasman implications of professional regulation and mutual recognition.

ACAP has an abiding concern for a wide range of functions that collectively assure the competence and fitness to practise of health professionals. These include the standards of entry into the profession, educational accreditation, registration, maintaining competencies and professional standards, promoting good practice, as well as processes for dealing with poor performance and misconduct.

While mindful of the financial implications of regulation, ACAP draws attention to the government’s obligations to ensure appropriate standards of public safety and the importance of establishing regulatory mechanisms commensurate with the real and perceived risks.

Regulation will always come with a cost somewhere within the system even if this does not have an immediate financial impact on government. The challenge is not just to minimise cost but to determine what form the competent authority should take in realising appropriate control mechanisms proportionate to risk.

ACAP draws attention to the dangers of expediency and moral risk with certain forms of employer-focussed regulation or unfettered self-regulation and highlights the need for a searching analysis of regulatory competency in determining the most appropriate form of regulatory authority. It suggests the principle of subsidiarity be applied in the systematic analysis and assessment of regulatory competency in delineating those areas and levels at which the State should or should not act to regulate a health profession.

ACAP also sees the need for additional consultation regarding the measures for assessing benefits and costs and (inter alia) suggests that overall decision making on regulation be guided by the use of a weighted assessment procedure.

Recommendations are made where deemed appropriate, and these form part of the detailed observations on the Discussion Paper proposals.

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“There is no such thing as free regulation.”

John Hutton
Making Europe Work Better – Fabian Society speech 4 July 2005
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Part 1 – Overview

**Australian College of Ambulance Professionals**

The Australian College of Ambulance Professionals (ACAP) is the national body representing the professional interests of paramedics in Australia. Its primary objective is to lead and develop the paramedic profession.

ACAP does this through the provision of research support; programs of professional development; publication; and other activities designed to enhance the standards of out-of-hospital Emergency Medical Services (EMS) that will protect the health and safety of the community.

It promotes best practices designed to achieve optimal patient outcomes and the integration of EMS with other health care programs to ensure a seamless patient care regime.

ACAP is concerned with a wide range of functions that collectively assure the competence and fitness to practise of paramedics. These include entry into the profession, education, clinical training, registration, setting of professional standards, promoting good practice, as well as processes for dealing with poor performance and misconduct.

In addition to membership-based activities, ACAP supports the development of the profession in the public interest and advocates the profession's policies and views to a range of external stakeholders in different forums.

Regulatory matters form significant areas of concern to the paramedic profession with the current absence of a national regulatory framework for paramedics in Australia. Given the implications of trans-Tasman professional interactions, and the proposed registration of paramedics in New Zealand, the question of appropriate criteria for statutory regulation is thus a matter of particular interest.

**Background to the review**

Since September 2004, New Zealand health practitioners have been regulated under the Health Practitioners Competence Assurance Act 2003 (HPCAA). The HPCAA brought all previously registered health professions (with separate statutes), under a single regulatory framework.

The HPCAA incorporates the major concepts of the earlier Medical Practitioners Act 1995 but is written in generic terms to make it applicable to all health practitioners, with consistent procedures and terminology across all the regulated health professions.

The paramount purpose of the HPCAA is to protect the health and safety of the public where there is a risk of harm from the practice of a profession. It does this by providing a regulatory framework for practitioners that includes mechanisms to ensure their life long competency and fitness to practice. The Act also separates the registration process from the disciplinary process.

The New Zealand Ministry of Health administers the Act, including managing the consultation processes to enable the Minister to appoint the members of the various registration authorities established under the Act.
Primary responsibility and accountability for registration activities falls on the relevant registration authorities, which are responsible for:

- describing their professions in terms of one or more scopes of practice with associated qualifications
- registering and issuing annual practising certificates to practitioners who have shown continuing competence
- reviewing and promoting ongoing competence
- considering practitioners who may be unfit to practise
- setting standards of clinical competence, cultural competence and ethical conduct
- establishing professional conduct committees to investigate practitioners in certain circumstances.

**Restricted Activities under the HPCAA**

Key protections provided by the HPCAA are that:

- Only health practitioners who are registered under the Act can use the titles protected by the Act or claim to be practising a profession regulated by the Act
- Registered health practitioners are not permitted to practise outside their scopes of practice
- Registration authorities are required to certify that a practitioner is competent to practise in their scope of practice when they issue an annual practising certificate
- Certain activities are restricted and only able to be performed by registered health practitioners.

The HPCAA allows for specified activities to be restricted to registered health practitioners, and it is illegal for anyone other than a registered health practitioner to perform any of these defined activities except in an emergency.

The HPCAA originally applied to 15 registration Authorities covering one or more health professions but was enabled to cover other professions should the need arise. This may involve the establishment of either a new registration authority or that a designated profession be added to an existing authority – thus creating a “blended authority”.

New or blended authorities do not receive funding support and the set up and operational costs of a new authority must be borne by registrants. The financial viability of any proposed authority is therefore of relevance to any profession seeking to be regulated by a registration authority, or for that matter, any form of regulatory control.

The Act also provides for a separate Health Practitioners Disciplinary Tribunal to hear and determine disciplinary proceedings relating to all registered health practitioners. The Tribunal comprises a chairperson, three deputy chairpersons and a panel comprising lay persons and health practitioners. All members of the Tribunal are appointed by the Minister of Health.
Since the Act commenced only one profession has been added: the Psychotherapy Board of New Zealand, which was established in October 2007. At that time Cabinet noted the high costs associated with setting up a separate authority for this small group of professionals and expressed concern about the potential proliferation of responsible authorities.

Concern was raised that too many registration authorities with overlapping scopes of practice may lessen flexibility in the health sector as practitioners must then comply with the qualification requirements and competencies set by multiple authorities.

Each authority must describe the contents of the relevant profession in terms of one or more scopes of practice and designate the qualifications applicable to any scope of practice. This may be a degree or diploma of a stated kind from an educational institution accredited by the authority or an educational institution of a stated class, whether in New Zealand or abroad (an expanded description of the qualification requirements may be seen at http://www.moh.govt.nz/hpca).

Any profession seeking regulatory inclusion must conform to the primary purpose of the Act which 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 (s 3(1))”.

Implicit in the Act is the protection of the public interest through transparency by ensuring that the public can readily determine what services a health practitioner is competent and entitled to provide. The underlying concept is to provide the public with clear information on the nature of a profession, and the scope of practice and competencies of its practitioners.

Policy framework for occupational regulation

The arrangements for registration of healthcare professionals are consistent with the more general New Zealand policy framework for regulating occupations.\(^1\) This states that the aim of regulation is broadly to protect the public from the risks of an occupation being carried out incompetently or recklessly.

The policy framework for occupational regulation requires those proposing regulation to identify the risks posed by a particular occupation and the best means of dealing with them.

The statutes and procedures vary from occupation to occupation. In general, occupational regulation in statute is designed to protect the public from physical, mental or financial harm by:

- providing barriers to entry, such as the possession of particular qualifications and assessment of character
- enforcing rules of practice and providing for disciplinary procedures
- where clients’ money is involved, providing a form of insurance through bonds or similar devices
- requiring providers of services to disclose information that will assist consumers to assess the service.

\(^1\) Policy Framework for Occupational Regulation, Cabinet Office (99)6, 8 June 1999 http://www.dpmc.govt.nz/cabinet/circulars/co99/6.html
The governance measures to achieve these outcomes vary according to the occupation and will not always involve intervention by the government or legislation. Moreover, Cabinet Office Circular No (99) 6 dealing with regulation\(^2\) is based on the premise that:

- Intervention by the government in occupations should generally be used only when there is a problem or potential problem that is either unlikely to be solved in any other way or inefficient or ineffective to solve any other way.
- The amount of intervention should be the minimum to solve the problem.
- The benefits of intervening must exceed the costs.

ACAP agrees with these objectives and notes that they generally reflect the well-established principle of subsidiarity as defined in Article 5 of the Treaty establishing the European Community.\(^3\)

The European Community has long grappled with regulatory issues spanning diverse professions and jurisdictions. The underlying objective has been to ensure that decisions are taken as closely as possible to the citizen, and to determine whether action at Community level is justified given other options available at local, regional or national level.

In essence, the subsidiarity principle requires that the European Union not take action (except in the areas which fall within its exclusive competence) unless it is more effective than action taken at another level. Subsidiarity is closely associated with the principles of proportionality and necessity.

Together these principles require that there be a systematic analysis of the impact of legislative proposals and the use, where feasible, of less formal measures with the devolution and decentralisation of public responsibilities to the degree possible.

Application of the concept of subsidiarity to professional services is valuable in serving to highlight regulatory competency and relevance, and to delineate those areas and levels at which the State should or should not act. In this context, regulatory action taken by the State should comply with the following criteria:

a) The action must be necessary because the actions of individuals or organisations alone will not achieve the desired objectives (the necessity or sufficiency criterion).

b) The action must bring added value over and above what could be achieved by individual or organisation-led actions alone (the benefit criterion).

c) Decisions should be taken as closely as possible to the affected community (the close to the citizen criterion).

d) The action should secure greater freedoms for the individual (the autonomy criterion).

These aspects are of significance in the regulation of health professionals and will be addressed at various times in the following discussion.


Part 1 – Regulatory principles

Professionalism and labour mobility

The scope and form of regulation varies widely between professions and between countries. \(^4\) Regulation may range from qualification requirements for individual practitioners to inclusion of the service provider function, with licensing requirements for firms. In some cases regulation also includes the specific service by setting mandatory performance standards.

The responsibilities and roles taken by professional bodies also vary widely across professions and countries (and in some cases within countries). In most jurisdictions, professional associations play a prominent role in the regulation and practice of the profession because of their close links with practitioners and their capacity to mobilise relevant expertise and practice competencies. Many regulatory arrangements are executed by a profession through a self-regulatory regime with or without the ultimate protection of legislation.

Some professional fields have stringent character requirements in addition to qualification and practice competencies e.g. teaching.

Regardless of the mechanisms, a continuing theme in discussions about the regulation and registration of professions is the portability of skills and mobility of practitioners.

In ACAP’s view, the registration of health professionals and the creation of a national register that records an individual practitioner’s skill and knowledge level are important elements in achieving reciprocity of recognition across jurisdictional boundaries and in fostering workforce mobility.

ACAP believes such mobility is crucial for the health professions to ensure equity in health care. It assists workforce sustainability and advancement that benefits the community through better access to quality care.

Recent developments in Canada reinforce this view with its 1995 Agreement on Internal Trade \(^5\) that had the goal of facilitating the free movement of people, investments and services across Canada.

Despite the Agreement, challenges continued to face certain regulated occupations. While many occupations enjoyed a high degree of consistency in regulatory requirements, workers nonetheless encountered barriers when they moved from one jurisdiction to another because of differences in certification requirements. To help resolve labour mobility issues, in January 2009, the premiers and Prime Minister endorsed amendments to Chapter 7 of the Agreement regarding interprovincial labour mobility.

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\(^4\) Extending the Disciplines on Domestic Regulation for Accounting to other Professional Services, Patricio Contreras, PECC Trade and Investment Issues in WTO and APEC Study Group on Services, Focus Workshop on Trade September, 2003

http://www.ait-aci.ca/index_en/ait.htm
Under these amendments “labour mobility” means that any worker who is certified for an occupation by a regulatory authority in one province or territory of Canada shall, upon application, be certified by another province in Canada with no further assessment, training or experience requirements.

For example, the levels of practitioners and the scopes of practice for paramedics vary across the Canadian provinces, with Alberta practitioners having one of the broadest scopes. In the past this has resulted in an exemption from the Agreement on the grounds of a material scope of practice difference, since practitioners from other provinces generally did not have the necessary competencies or training to meet the scope of practice requirements for Alberta.

Implementation of the amended Chapter 7 involves all provinces, territories and the federal government, as well as regional and national organisations concerned with occupational certification and licensing. A national co-operative process is underway and jurisdictions and regulatory bodies are sharing best practices in this participative process.

These initiatives are already having an impact. In February 2010 the Government of Canada announced that the Alberta College of Paramedics will receive, on behalf of paramedic regulatory authorities across Canada, more than $1 million for the collaborative development of a single national standard and process for the qualification, assessment and certification of paramedics, leading to full labour mobility for paramedic practitioners.6

Australia also has faced similar problems and in 1992 Australian Health Ministers agreed that mutual recognition was an important step towards agreed national standards for health occupations. Mutual recognition helps to ensure that health practitioners registered in one State or Territory are automatically entitled to registration in any other State that registers that occupation.

Among the implications of the 1992 Mutual Recognition Agreement and the subsequent enabling legislation, is that by default, the minimum standard of education set by one State for registration automatically becomes the standard for registration in all other jurisdictions.

In concert with the mutual recognition principles, Health Ministers agreed in 1993 that no further action would be taken to regulate any additional health occupations unless the need for doing so had been agreed by the Australian Health Ministers Conference (via the Australian Health Ministers Advisory Council (AHMAC)).

In April 1993, AHMAC established a Working Group to provide advice on the procedures for the assessment of statutory regulation of (then) partially regulated and unregulated health occupations. The outcome of that process7 was the formulation of six criteria for regulatory assessment. These constitute the so-called 1995 AHMAC criteria for assessing the regulatory requirements of unregulated health occupations referred to in the Discussion Paper.

6  www.collegeofparamedics.org/pages/Registration/AgreementonInternalTradeMutual
RecognitionAgreement.aspx
Of particular significance is the further agreement between Australian and New Zealand jurisdictions of the 14 June 1996 relating to Trans-Tasman Mutual Recognition, implementing mutual recognition principles regarding the sale of Goods and the Registration of Occupations, consistent with the protection of public health and safety and the environment.

Europe has recognised the importance of professional mobility and the need for reciprocity. The European Union has made great efforts to improve and simplify the regulatory environment in promoting cross border trade and competition for professional services, thus generating intense discussion on the nature of regulatory frameworks.\(^8\)

European Directives have been notably implemented for the medical profession such that medical qualifications obtained in any state are now recognised by each member state. After registration in the professional body, a physician can practice under the rules of the particular country of registration.

Significantly, entry qualifications and education programs form only part of an effective regulatory regime. The competencies framework and the maintenance of professional competence are other key factors, and while educational accreditation is a crucial element, it is only one piece of the jigsaw comprising the fabric of regulation.

Internationally, the impact of regulatory activities on the health professions has become part of the public policy and mutual recognition agenda. Furthermore, the realisation has grown that the underlying principles and practices of regulation are founded on common principles that should form the primary determinants governing the decision to regulate a health profession.

**Why regulate at any level?**

The market-based rationale for regulation suggests that when faced with a choice of service providers, many consumers may be unable to make a rational choice. Professional services are taken at face value, with the consumer generally having to rely on the expertise of the practitioner and not well placed to assess the nature and quality of the service.

Regulation of a profession therefore may be justified if it can provide some protection for the consumer through guaranteeing the quality of service by virtue of the regulatory body having more information and expertise at its disposal than the average consumer - and using that knowledge in licensing the practitioner.

If the service activity at a practitioner level is provided in conjunction with an agency function (such as a hospital, clinic, diagnostic service or EMS provider), then the public interest becomes multi-dimensional.

There are two regulatory regimes to consider, involving both individual and provider considerations. The degree of interdependence becomes significant and if the practitioner is also an employee, the moral risks greater, such that the provider accreditation and competency issues warrant separation from the practitioner role and fitness-to-practice issues.

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\(^8\) Stocktaking Exercise on Regulation of Professional Services, Overview of Regulation in the EU Member States, 2003
In real life there are often significant constraints on the services market with only a single service provider being available, so that consumers/patients are unable to make a free choice between competing services. In rural and remote areas, these constraints become even more marked. These factors may well justify regulatory controls that mandate adequate information disclosure with respect to maintaining professional standards and quality of service.

The failure to have an open market for services gives rise to another reason for some form of regulation. Many health services fall into the category of a public good and information concerning the quality of professional services may not be transparently available.

In Australia the question of transparency has assumed greater significance across other professional fields including education, with the release of the “My School” website containing important information about each of Australia’s 10,000 schools including the number of students and teachers at each school and how the school is performing in national literacy and numeracy testing.

The overwhelming public response, with more than 1.5 million website hits within the first 24 hours, is strong evidence of the community’s desire for engagement in matters relating to service quality and performance. Similar measures to promote transparency are being developed for healthcare under the Australian Government’s current health care reform agenda.\(^9\)

Healthcare, with its multiple participants and layers of interaction between different practitioners and providers, is subject to greater than normal public interest and consumer protection considerations. Not only are consumers commonly unable to judge the expertise of the individual professional but they are frequently faced with no choice of provider. Where there is no real choice in matters involving risk to the public, some form of independent licensing and performance reporting (or an equivalent regulatory mechanism) becomes not optional, but mandatory.

While the case for regulation in the public interest should not be controversial, it remains unclear which form the regulation should take. A graded response may be appropriate based on the overall perceived risk and public interest. Once the basic quality of service is assured (the necessity criterion), generating confidence and trust in the profession appears paramount and regulation should aim at enhancing that trust relationship (value added criterion).

Some professions stress the need for self-regulation, on the basis that only a rigorous system of peer review is satisfactory to limit the risk of poor quality service.

The impact of these risks is conspicuous in the health sector and the consequences of maltreatment go well beyond the immediate patient outcomes. Public expectations and perceptions play a significant role and any suspicions of inadequacy generate serious public concerns and loss of public confidence.

In that respect, the bare self-regulatory model suffers from perceptions of self-interest, conflict of interest, lack of accountability and lack of community (citizen) engagement.

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The tendency of self-regulating professions to protect their scope of practice as a means of benefiting their members has been consistently noted in studies of professional regulation inside and outside of health care.\textsuperscript{11}

ACAP eschews any calls for regulation that may stem from private interest or the regulation of professional services because it is in the interests of the members of the profession or service provider / employer group. Regulation in this context operates like a cartel. In theory, selective professional regulation and licensing may restrict supply, increase the perceived value and incomes and promote exclusivity and status without contributing materially to public health or safety. It can also mask poor governance, restrictive practices, internal divisions and professional rivalries and disputes.

The community might expect government to protect it from such influences but self-seeking behavior is difficult to identify and separate from other sound public interest arguments for regulation. In a democratic society, legislation involving the public interest is also subject to lobbying and pressure from multiple groups including the profession in question.

Auditing professional bodies for compliance, using benchmark measures and forcing the functional separation of professional, service and complaint/disciplinary matters internally may minimise the likelihood of self-serving practices. These activities are at best additional control mechanisms and responses to ensure the integrity of the regulatory processes and therefore likely to remain as governmental functions and introduce additional costs.

Thus, while strongly supporting the case for substantial involvement of front-line practitioners in the regulatory process, ACAP notes that devolution does not remove the ultimate cost to the consumer despite potentially reducing the visible financial impact on government.

The benefits to be gained from government intervention in economic terms through consolidation, scale, and independence therefore should not be underestimated, especially when allied with perceptions of the public interest.

**Applying best practice principles to health regulation**

There is no single model for regulatory best practice. However, one must be mindful that a key aspect of the subsidiarity principle is to decentralise to the lowest competent authority. The trouble with empowering for example, employer groups or industry associations with regulatory functions, is that they are subject to rent-seeking, limited vision, moral risk and tempted to seek progress in their own interests, thus rendering their competency suspect in the public interest.

Recent times have demonstrated how corporate social responsibility demonstrably lags far behind immediate stakeholder and management interests, and the ethos of government responsibility and ethical accountability for the public interest generally is not matched by any other sector.

That being so, ACAP suggests that the issue to be addressed is not so much the relative cost of different regulatory regimes as suggested in the Discussion Paper, but the issues of competency and appropriateness, while concurrently fulfilling the sufficiency, benefit, close to citizen and autonomy criteria (see earlier).

In the words of the Rt Hon. John Hutton, former UK Secretary of State for Business, Enterprise and Regulatory Reform: “there is no such thing as free regulation.”

The real challenge therefore is to integrate the protection of the public with the level of primary risks associated with professional practice and match these factors with the necessary (sufficient) and available control and regulatory mechanisms.

Government carries a heavy burden of responsibility to ensure that any devolution of responsibility for protecting the public interest extends only to a competent and independent body which demonstrates all the elements of good regulatory practice in order to hold public confidence in its independence and objectivity.

Considerable work has been done in the UK on the regulation of health care and health professionals as a result of highly public Inquiries which forced a reappraisal of the handling of complaints, the role of the General Medical Council and the revalidation of doctors.12

In addition, general principles of good regulation have been developed by the UK Better Regulation Task Force (BRTF) under the Better Regulation Executive (BRE).13 The BRE guidelines say that regulation should be:

- **proportionate**: regulators should only intervene when necessary. Remedies should be appropriate to the risk posed, and costs identified and minimised.
- **accountable**: regulators must be able to justify decisions, and be subject to public scrutiny.
- **consistent**: Government rules and standards must be joined up and implemented fairly.
- **transparent**: regulators should be open, and keep regulations simple and user friendly.
- **targeted**: regulators should be focused on the problem, and minimise side effects.

When dealing with healthcare, these views are further supported by the statement articulated by the UK Ministry of Health14 of the key principles that should underpin statutory professional regulation, viz:

“First, its overriding interest should be the safety and quality of the care that patients receive from health professionals.


Second, professional regulation needs to sustain the confidence of both the public and the professions through demonstrable impartiality. Regulators need to be independent of Government, the professionals themselves, employers, educators and all the other interest groups involved in healthcare.

Third, professional regulation should be as much about sustaining, improving and assuring the professional standards of the overwhelming majority of health professionals as it is about identifying and addressing poor practice or bad behaviour.

Fourth, professional regulation should not create unnecessary burdens, but be proportionate to the risk it addresses and the benefit it brings.

Finally, we need a system that ensures the strength and integrity of health professionals within the United Kingdom, but is sufficiently flexible to work effectively for the different health needs and healthcare approaches within and out with the NHS in England, Scotland, Wales and Northern Ireland and to adapt to future changes.”

ACAP suggests that the principles for regulation also must incorporate:

- Effectiveness – the regulatory system should be effective in protecting the public from harm and fostering the provision of high quality health care
- Accountability – registration processes should provide accountability to the community for their decisions and operations.
- Transparency – the decision making processes should be open, clear and understandable both to consumers and to practitioners
- Fairness – registration boards should maintain an acceptable balance between protection of patients/consumers rights and interests, and those of the regulated health professions
- Efficiency – the resources expended and the administrative burden imposed by the regulatory system should be commensurate with the level of risk regardless of where in the system these costs are incurred
- Consistency - there should be consistency across different jurisdictions in the regulatory arrangements for the health professions (for example, between closely related sovereign states like New Zealand and Australia and their internal legal structures).
- Flexibility – the regulatory system should be able to respond to emerging issues in a timely manner as the health care system evolves and the roles and functions of health professionals change.

While these principles provide guidance on the objectives and outcomes of regulation, and indicate some structural directions, they leave the detailed mechanisms unstated.
Identifying regulatory competence

It is in the interests of all stakeholders to have regulatory mechanisms that hold public confidence. As noted previously, regulatory systems vary substantially across industries and countries. Even so, the characteristics of good regulatory governance are increasingly being recognized as: clarity, predictability, autonomy, accountability, participation, and open access to information. Each of these factors aids in making a regulatory system transparent in the eyes of stakeholders, and enhancing the outcomes.

Worldwide regulatory practices already espouse the transparency principle. Almost all regulators now maintain open Web sites and publish annual reports with information about the regulator, the regulated persons or entities, and the regulatory decisions made in each year. The nature and content of reporting vary substantially, reflecting the wide range of requirements for information disclosure.

In his landmark review of legal services Sir David Clementi formed the view that for effective regulation and public confidence it was desirable for some regulatory functions to be carried out by bodies that are wholly separate from the professional associations or service providers.

The chief of these externalised functions are client complaints, disciplinary matters and the setting of practice rules.

In this respect, when considering the management of complaints, there is a consistent opinion that they should be handled independently of a profession to properly command public support. The separation of functions provided by the HPCAA is thus seen to hold several desirable attributes.

Furthermore, it was Clementi’s view that clients should have access to a single body in order to make complaints and not be expected to navigate a complex series of complaint processes. To serve the public interest, the complaints body also needed to have a substantial non-professional membership.

ACAP supports these principles and notes the improbability of providing comparable provisions that ensure independence within any regulatory system that is primarily composed of either employers or practitioners.

Regulatory systems and complaint mechanisms are needed to meet community expectations of engagement and user-focus, rather than systems that are primarily profession or service-focused.

Employer-based controls on a regional or jurisdictional basis may be able to create a strong regulatory framework, but the absence of independent and objective examination of professional practice matters is perceived to severely disadvantage the individual practitioner and breach several regulatory principles.

15 Lorenzo Bertolini, *How to improve regulatory transparency, Emerging lessons from an international assessment*, GRIDLINES, Note No. 11 – JUNE 2006

16 Review of the Regulatory Framework for Legal Services in England and Wales Final Report
Sir David Clementi., December 2004

17 The Future of Legal Services: Putting Consumers First , Response of the Legal Aid Practitioners Group, January 2006 (response to White Paper on reform of the legal services sector October 2005)
http://www.lapg.co.uk/docs/LAPG%20response.pdf
A system of quasi-regulation where the employer sets the rules, processes complaints and determines the outcomes across both professional (fitness-to-practice) issues and employment-related issues is fundamentally conflicted and contrary to natural justice. The public interest in the fairness and transparency of the regulatory process also demands that there be meaningful lay representation.

For example, professional disciplinary matters may or may not involve fitness-to-practice issues or a direct patient complaint. At the same time, a service complaint may be unrelated to the performance of a practitioner. In some cases service quality is impacted through an intermingling of causes with both the practitioner and infrastructure provider (hospital, clinic, emergency service) potentially contributing to adverse outcomes.

The end result should be two separate quality assurance and complaint modes to cater for matters pertaining to the professional on the one hand, and infrastructure service delivery issues on the other. Under a properly constituted set of complaint mechanisms these two modes could be combined in the form of a “one-stop-shop” to simplify the complaint process and make the process easier for the user/patient.

In the Australian context this separation of functions is reflected in the establishment of various public complaint mechanisms such as the Western Australian Office of Health Review,\(^{18}\) or the Queensland Health Quality and Complaints Commission,\(^{19}\) in addition to current moves to establish a national professional regulatory framework for regulated health professions.\(^{20}\)

Employer-based regulatory controls thus do not meet the competency test under the principle of subsidiarity, and a broader and more representative structure at a higher level of competency is required. Given the nature of many health professions and the well-established desire for professional mobility, this will normally require a national focus and statutory regulation if the risks surpass a given threshold of concern.

The determination of statutory regulation in this context is not simply a matter of cost but one also of consequences. To be acceptable, the needs of consumers and the public interest must be at the heart of any regulatory system.

**Identifying the public interest**

One of the key issues to be resolved in regulation is the identification and assessment of the public interest. ACAP considers that Ontario provides a good reference yardstick for this purpose.

The Ontario Health Professions Regulatory Advisory Council (HPRAC) is a broadly representative body that gives independent advice to the Minister of Health and Long-Term Care on matters related to the regulation of health professionals. This includes (inter alia) whether unregulated health professions should be regulated, whether regulated professions should no longer be regulated, the nature of amendments to the *Regulated Health Professions Act* (RHPA) (e.g. amendment Bill 179, *Regulated Health Professions Statute Law Amendment Act*, 2009) and other matters referred to it by the Minister.

\(^{18}\) http://www.healthreview.wa.gov.au
\(^{19}\) http://www.hqcc.qld.gov.au/home/default.asp
In an insightful study carried out for the HPRAC\textsuperscript{21} the “public interest” was explored in depth, with the outcome being the view that it is best promoted by adherence to the six fundamental objectives that underpin the RHPA.

These objectives and their associated criteria identified by the study are paraphrased below:

**Criterion #1 - Protection from harm**

The RHPA embodies the protection from harm principle through a number of key provisions and mechanisms such as the harm clause (section 30), the scope of practice regime (including the scope of practice statements for each profession, the controlled acts, the authorised acts and title protection) and the various regulations made under the RHPA.

**Criterion #2 - Quality care**

The RHPA attempts to ensure that the care provided by individual regulated health care professions is of high quality and that the standard of care provided by each regulated health professional is maintained or improved. This can be seen in numerous provisions such as: entry to practice requirements, competency reviews, patient relations programs and Quality Assurance Committees in the governing regulatory Colleges.

In addition, Colleges have the authority to make Codes of Ethics for their members, to make regulations about standards of practice and to define “professional misconduct”.

No person, other than a member treating or advising within the scope of practice of his or her profession, shall treat or advise a person with respect to his or her health in circumstances in which it is reasonably foreseeable that serious physical harm may result from the treatment or advice or from an omission from them.

**Criterion #3 - Accountability**

Under the RHPA, regulated health professionals are accountable to their patients/clients, Colleges and the public. This accountability is promoted through various provisions such as: the complaints and discipline process, the public’s access to information on the register, patient relations programs and the public/professional composition of College Councils.

**Criterion #4 - Accessibility**

Another public interest objective of the RHPA is that individuals have access to services provided by the health professions of their choice. Further, the notion of accessibility includes not only access to health professions but also to the regulatory system as a whole.

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**Criterion #5 - Equity**

The principle of equity embraces the concept of procedural fairness as well as equalisation of benefits or outcomes. The intent of the RHPA was to ensure that all individuals are treated with sensitivity and respect in their dealings with health professionals, the Colleges and the Board. The notion of procedural fairness can be seen in the RHPA by the provisions for: the right to notice and submissions before Committees as well as all procedural and evidential rights under the Health Professions Procedural Code (HPPC) and the Statutory Powers Procedure Act.

**Criterion #6 - Equality**

Equality of regulatory obligations among health care professions is considered to be in the public interest. The legislative objective of equality is achieved through the application of a common regulatory framework to all professions, despite their differences in scope of practice or their overlapping scopes of practice. The RHPA treats all regulated health professions the same and obliges all governing Colleges to adhere to the same corporate structure, purposes and procedures.

ACAP supports the general thrust of these findings as providing guidance and a framework for determining the public interest.

**Proposals for change in regulatory assessment procedures**

The underlying reason advanced for change is the requirement that the Ministry needs to be ‘explicit about the criteria that will be used to advise the Minister as to whether regulation is justified’. ACAP also notes that in approaching this issue, the decision has been made to adopt similar principles as the United Kingdom, Ontario and Australia in considering applications from new professions seeking regulation.

In determining whether those overriding principles have been met, the Ministry has proposed that more explicit second-level criteria, based on the Australian AHMAC criteria and that these be used to inform applicants with subsidiary criteria to provide a clearer understanding of where the threshold for statutory regulation lies.
Part 3 - ACAP observations on individual issues

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<tr>
<th>Discussion Point 1</th>
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<td>Are the principles for regulation set out in section 9 of the discussion document appropriate? If not, why not?</td>
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ACAP agrees with the overriding principles for regulation outlined in section 9. In particular it notes the well articulated description of the delivery of a health service which places a focus on the functions performed by the professional practitioner in terms of individual outcomes.

ACAP has consistently called for the recognition of healthcare that begins with the patient (wherever and under whatever circumstances that may prevail) and not something that begins at the hospital or clinic door.

Thus it may be the healthcare assessment by a radiographer or diagnostician, the primary and preventive care from a nurse practitioner or the interventions performed by the paramedic that equally qualify for recognition as a health service as do the more traditionally accepted activities of a medical practitioner, pharmacist or dentist.

In supporting these principles, ACAP draws attention to the significance of the words “appropriate means” when referring to regulation. Care must be taken not to adopt a facile approach driven by expediency and immediate financial impacts. Assessment of need must follow a rigorous process that embraces the principle of subsidiarity in determining the nature and composition of the competent authority that meets the overall regulatory objectives.

Professional practice also incorporates more than the concept of the individual or sole practitioner and the implications of employed professionals must be considered. Regulation of employed professionals by an industry-oriented employer group would not be appropriate, nor would a self-regulatory regime be acceptable if it lacks independent community and broader stakeholder participation. Both these options also would require independent and participative complaint mechanisms to ensure minimal conflict of interest and to meet the ‘close to the citizen’ criteria.

ACAP also notes the potential difficulty in defining the public interest in a meaningful manner and recommends that the nominated criteria #1 to #6 (pp 20-21) be considered as a general basis for determining this issue (see Criterion 1 of Discussion Point 2).
Discussion Point 2

Are the criteria set out in section 10 of the discussion document appropriate? If not, why not?

This Discussion Point is multi-faceted and involves several criteria suggesting that a separate treatment of each criterion may be most appropriate.

Criterion 1: The activities of the profession must pose a significant risk of harm to the health and safety of the public.

ACAP agrees that a key trigger for regulatory intervention is the potential for significant harm to the consumer (or a third party). ACAP also notes the interrelationship between the public interest and the perceptions of risk to public health and safety. The harm criterion also contains elements of a ‘chicken and egg’ conundrum in that the risk of harm may be a consequence of a lack of regulation.

Numerous research studies have shown how perceptions of risk may be skewed and vary with circumstances with some difficulty being experienced in developing acceptable and objective measures of risk. ACAP therefore agrees that while this criterion is appropriate in principle it must be interpreted in context.

Nearly all occupations have the capacity to cause some harm, but given the costs of compliance, intervention may be reasonably limited to cases where the harm has the potential to be significant.

The existing NZ Policy Framework for Occupational Regulation provides useful guidance in this respect. Significant harm is defined as significant harm to one person or moderate harm to a large number.

Moderate harm to a large number might arise from one event or from the aggregated actions of different providers of a service. Significant harm that is irreversible (such as permanent disability) is more likely to justify intervention than reversible harm.

The case for involvement in regulating an occupation is thus subject to a degree of interpretation by public policy makers. Concepts such as "significant harm" cannot be defined with precision and may mean different things under different circumstances.

For this reason the determination of significant risk need to be applied in the light of the particular circumstances relating to an occupation. Harm takes many forms and may involve less obvious mental harm as well as physical harm. Because of the interplay between harm and the public interest ACAP recommends that the nominated criteria #1 to #6 (pp 20 - 21) also be employed in determining this issue.

The interplay between risk and harm in determining the likelihood of regulatory intervention is also shown graphically below (taken from the Policy Framework for Occupational Regulation).
Risk Assessment Model to Determine Regulatory Intervention

By way of example, the professional and clinical activities of paramedics are aimed at preserving life, preventing further illness or injury and promoting patient recovery. Like in many medical practices, the work varies from low to high risk where the interventions, based on clinical indications, clearly pose a serious risk of harm to the health and safety of the patient (public).

Paramedics must make time critical decisions about the immediate administration of restricted, powerful and potentially dangerous drugs. Unlike some other related health professions, the responsibility for the administration of these drugs in an emergency situation may well rest solely with the paramedic.

Paramedic practice also comprises a range of physically invasive procedures that involve varying degrees of risk to the patient. The highest risk procedures such as sedation, paralysis, endotracheal intubation and artificial ventilation are known to have potentially fatal consequences if the paramedic’s clinical judgment is in error or through poor execution of the procedure.

Paramedic practice thus has a combination of many lower or moderate risk activities and a substantial number of high risk activities cumulatively giving rise to what must be assessed as ‘significant risk’ to the public.

ACAP supports similar (relevant) risk assessments for all professions seeking regulation, but cautions that while the risks may be clear-cut for paramedics, other areas involving (say) preventive health and mental health may have less obvious but equally valid ramifications and will need careful and sensitive treatment.
Criterion 2: Existing regulatory or other mechanisms fail to address health and safety issues.

ACAP agrees with this criterion with the caveat that the terminology should be changed to ‘appropriately address in a transparent and comprehensive manner’.

In some cases the existing statutory regulatory and self-regulation mechanisms for a profession may not be present and the determination is clear cut.

In other cases, however, processes of self audit and clinical review may be present but not robust, or may focus on aspects of performance that are primarily designed for the purposes of clinical reporting at the macro level, rather than key performance indicators based on the execution of the professional practice itself.

In other circumstances (especially for employed professionals) the focus may be inappropriate and create tensions between the exercise of clinical judgement and restrictive controls driven by an ‘employer bias’. The financial implications to the employer arising from regulatory issues may create an environment of moral risk leading to tensions between the clinical and operational demands. Regulatory controls under such circumstances again would not be desirable.

Employer-driven regulation also tends to create a situation of restricted practitioner mobility and economic thralldom which is effectively a restriction of trade and not in the public interest. For example, in Australia where there is currently no national registration framework for a paramedic, if a practitioner chooses to leave their employment with a statutory EMS service provider, they effectively lose the right to practice their chosen profession quite regardless of their fitness-to-practice. They are merely avatars to be switched on or off as the provider wishes. ACAP considers this to be an unreasonable and unfair restriction on a paramedic’s ability to maintain their clinical practice skills.

The subsidiarity test of competence also applies in this situation (see pp18 – 19) and ACAP contends that the combination of moral risk, conflict of interest, natural justice, and competency, make it inappropriate for an employing body to serve also as the professional regulatory authority body and possess such influence on an individual’s right to determine their access to clinical practice.

Another circumstance that might arise is for other groups of registered practitioners supervising the activities of the profession. Similar issues apply as for employer groups. Short of being present and holding the hands of a practitioner, and providing guidance in decision-making, such a model holds no discernible advantage and it will still be the knowledge and skill of the practitioner that determines the outcome of any intervention or procedure. ACAP supports the concept of a blended regulatory authority, but not the concept of ‘in loco parentis’ when dealing with professional regulation.

Thus It is not enough to demonstrate the existence of alternative regulatory mechanisms but that these be able to show their suitability for the purpose and ‘competence’ of the regulator.

Suitable sharing of regulatory responsibility between educationalists, practicing professionals and employers, and public engagement through lay participation with potentially an independent lay Chairperson are among the measures that would be necessary to meet the criterion of an appropriate alternative regulatory mode.
Regardless of the particular professional field, if these conditions are not met, then the answer again is determined in the negative – the regulatory or other mechanisms fail to appropriately address health and safety issues. Transferring responsibility for professional standards and regulation to an external statutory body therefore would be the preferred mode of regulation to protect the public.

**Criterion 3: Regulation is possible to implement for the profession in question.**

**Criterion 4: Regulation is practical to implement for the profession in question.**

ACAP believes these two criteria are closely related and are therefore best treated together in recognising and determining the ‘how’ of regulation.

Firstly, ACAP agrees that any group seeking regulation should be distinguished by the presence of those attributes normally associated with a profession. These distinguishing characteristics are usually the application of specialised knowledge and skills obtained through extensive education and training, a high degree of personal integrity in the delivery of services and a direct or fiduciary relationship with clients (patients).

Definitions abound, but the existence of a discrete body of knowledge, a defined scope of practice and competencies and a meaningful number of ethical practitioners are key requirements to identify a profession. These elements can be identified through data detailing the membership of a professional society and other sources of information.

Having determined that there is a legitimate basis for the existence of a profession, the question then becomes one of determining whether there are practical measures available for their regulation, or in other words, is it feasible to carry out the functions of regulation.

In this regard, ACAP supports the proposals articulated by Sir David Clementi who outlined the primary functions of regulation as:

- setting minimum entry standards and training
- formulating professional roles to which individuals are expected to adhere
- monitoring the individuals providing services
- enforcing professional roles where necessary
- implementing a complaints procedure; and
- implementing a disciplinary procedure for individuals who are negligent or breach the professional roles of practice.

Regulators also face the challenge of building the demand, awareness, and capacity of professionals, consumers and other stakeholders to participate effectively in the regulatory process.

AACAP recommends that applicants for regulation should be able to demonstrate that the profession is able to fulfill all these functional roles through the combination of suitable educational pathways, continuing education, and other ongoing professional activities.
Criterion 5: The benefits to the public of regulation clearly outweigh the potential negative impact of such regulation.

ACAP agrees with this self-evident criterion in principle but notes that the accompanying benefits and costs statement form a smorgasbord of ill-defined issues that in some cases are better described as functions of regulation and not measure of benefits or cost that are based on outcomes.

ACAP recognizes that any assessment of relative values will contain elements of subjectivity, perception and political value judgement, but is concerned that the present proposals contain many items that are of doubtful application and in some cases impossible or impractical to cost in realistic terms.

One struggles to attribute any value to the proposed cost of:

“…the significant anxiety for those professionals who fear that they may be deprived of their livelihood by vexatious complaints or unfair treatment…”

in the face of those same complaints being raised outside of a robust and independent regulatory framework. Many would say that regulation brings greater certainty and provides comfort to practitioners that all complaints will be handled fairly and with due process and therefore represents a benefit – not a cost.

Conversely no cognizance is given to the missing benefit statement that would consist of a statement like:

“.. the considerable reduction in anxiety and concern by the public with the assurance of appropriate standards of practice And competency …”

Why statutory regulation would imply a relatively high component of legal costs and be more open to challenge is also unclear, given that some form of regulation will surely be needed if the system is not to descend into anarchy.

In other cases the proposed costs as listed as the raw costs of regulation (wherever that may occur) rather than the incremental costs occasioned by statutory intervention over and above the costs that would necessarily be incurred to maintain an acceptable level of quality control and public safety.

In other words, contrary to the benefit criterion (p 9), the underlying assumption appears to be one of zero cost without legislated regulation. ACAP rejects this view as being contrary to the public interest which would mandate an appropriate level of protection in any event.

In yet other cases the mooted cost elements are also at odds with good regulatory principles and practices such as the cost attributed to:

“…the involvement of the regulator in some matters which are now dealt with internally by the employer, such as assessment of complaints....”

Suffice to say that the management of complaints and the separation of service issues from fitness to practice issues are precisely why some matters should not be handled by employers but involve a structured process with community engagement (for further details see pp 17 – 18 and the discussion on criteria 3 and 4 above).
There is also inadequate attention given to the potential benefits which may accrue in the public interest such as may be derived from application of the public interest factors outlined on pp 19 – 20. ACAP suggests that the evaluation of the public interest is critical in view of the importance placed on maintaining public confidence in the quality of healthcare as a community service.

Other concerns obtain with these proposals, relating to poor or inapplicable measures of value and cost which warrant broader and more nuanced discussion than is possible in a simple written submission. Since the benefit cost assessment is an essential part of the decision-making process for regulation this dialogue should take place as soon as possible.

ACAP strongly recommends the establishment of a representative round table discussion or forum and wider public consultation at an early date to address the matters to be considered as relevant benefits and costs of statutory regulation, with a view to developing a much more realistic set of measures for assessment prior to determination of any guidelines.

Criterion 6: It is otherwise in the public interest that the provision of health services be regulated as a profession.

ACAP agrees with this criterion in principle but again draws attention to the principles of good regulatory practice articulated by the BRE (page 15) and intended to ensure public protection through systems that are:

- Proportionate
- Accountable
- Consistent
- Transparent, and
- Targeted.

In addition to the nominated factors of the Discussion paper, ACAP recommends that the matters under Criterion 6 may also form part of the consultation program recommended for Criterion 5, taking into account the public interest factors outlined on pp 15 – 20.

Discussion Point 3

Are there any other criteria you think should be added to section 10 (of the discussion document)?

ACAP believes the proposed criteria for section 10 provide adequate coverage of all reasonable requirements for statutory regulation subject to the observations raised by ACAP above. At the same time, ACAP also notes that the contrary question has not been posed regarding the justification for statutory regulation.

That is, what factors may be considered relevant to deny statutory regulation in the case of health professionals whose interventions demonstrably pose a high level of risk to the public (see however, the subsidiary Criterion 6 of Discussion point 2).
ACAP believes that a hierarchy of justification should apply, and just as (say) individuals or companies would not be allowed to deal freely in nuclear technology or radioactive materials under a self-regulatory regime because of the inherent risks, so health professionals whose procedures or interventions hold particularly significant risks should be automatically subject to supra–competent (statutory) regulation.

ACAP also considers that the stated criteria only partially address the overall public interest, which should be further developed and articulated along the lines of the Ontario HPRAC study\(^{22}\) as outlined on pp 18-20.

**Discussion Point 4**

Do you agree that to establish a ‘risk of harm’ the profession must be involved in at least two of the following activities:

- invasive procedures
- clinical intervention with the potential for harm
- making decisions or exercising judgement which can substantially impact on patient health or welfare, including situations where individuals work autonomously, ie, unsupervised by other health professionals?

ACAP emphatically rejects the proposition that a profession must satisfy two or more of the suggested activities to meet the threshold of a ‘risk of harm’. Discussion about healthcare is often bedevilled by a clinical and interventionist philosophy without due recognition of the holistic nature of healthcare. Many procedures and professional endeavours in health may be diagnostic and preventive in their application with equal or greater impact on long term patient health without involving invasive procedures or direct clinical interventions.

On the other hand, interventions and invasive procedures may range, in the limit, from beauty treatments that might include the cutting of nails and abrasive skin treatments that are of relatively low risk compared to surgical incisions. The low-order procedures would be unlikely to qualify as definitive healthcare and the key in such matters is an appropriate assessment of the level of risk.

Risk is also relative and situational. For example, intubation of a trauma victim by a paramedic operating under emergency conditions in the field with adverse weather and lighting conditions is demonstrably higher risk than a similar procedure carried out by a registered medical practitioner under controlled clinical conditions in a hospital. Both procedures are clinically significant and qualify as a risky intervention under the stated criteria, but one carries substantially higher risk and requires a high order of judgement in its application.

Given that regulation applies to the practitioner and not to the procedure, ACAP considers that the hierarchy of justification should be based principally on the exercise of judgement which by itself meets the necessity criterion (p 9).

ACAP agrees that the extent to which the practice of the profession involves more than one of the suggested activities may well be used to determine the urgency for regulatory action or raise the level of significant response.

Discussion Point 5

Should a profession be required to meet all of criteria 1–5 to establish that the health services pose a risk of harm to the public? If not, what are the minimum criteria a profession should meet?

This discussion point is not entirely clear, since the question of risk of harm to the public is addressed by Criterion 1. Accordingly, it has been interpreted as seeking advice as to which criteria must be fulfilled to justify statutory regulation.

Here, as elsewhere, the final decision is one of judgement. The principles of necessity and sufficiency (p 9) suggest that a decision based generally on the balance of probabilities would be appropriate rather than a higher order of justification (such as requiring all criteria to be met and thereby creating an effective veto situation).

ACAP considers that a weighted assessment process would be most desirable, similar to the procedures adopted for tendering exercises with a larger weight assigned to the risk factor. Greater attention also needs to be given to which factors might be mandatory requirements and which are more reasonably considered desirable attributes or measures.

Consideration should be given to the necessary and sufficient scores that should apply in total and individually, given that many aspects are based on perceptions and value judgements for which the variance of assessment may be quite large.

Discussion of minima therefore is not entirely appropriate, but ACAP would view the substantial risk criterion (Criterion 1) as mandatory and the other criteria as less binding.

Discussion Point 6

Do the proposed criteria provide sufficient guidance on what factors will be taken into account in establishing whether it is ‘otherwise in the public interest’ to regulate a profession?

In general terms the answer is Yes. However ACAP notes that a number of changes are needed and that the stated criteria should be further developed and articulated along the lines of the Ontario HPRAC study as outlined on pp 18-20.

Discussion Point 7
Should applicants be given the detailed guidelines outlined in section 11 (of the discussion document)?

Yes. The principles of probity and accountability apply in such matters and applicants should be given all material information that will properly inform their submissions. Once again the probity conditions that apply for government procurement provide a good model for the required information and communication protocols that should apply and ACAP will provide further information in this regard if requested.

Discussion Point 8
Should any other matters be included in the guidelines outlined in section 11 (of the discussion document)?

At this time ACAP has no particular issues to raise, although the outcome of additional consultations (Discussion point 2 - criteria 5 and 6) may well give rise to further proposals.

Discussion Point 9
Should any other information be added to the application form to guide applicants?

ACAP sees no need for further information other than the normal identification, confidentiality provisions (as relevant) and administrative procedures.

Discussion Point 10
If the revised criteria are confirmed, do you have any comments about the timing for introducing the new criteria? In particular, do you have any comments about how introducing the proposed changes might impact on the new professions that currently have applications with the Ministry?

The Ontario criteria #5 (Equity) and #6 (Equality) outlined on p 20 embrace the concepts of procedural fairness as well as equalisation of benefits or outcomes. The notion of procedural fairness is embodied in provisions for the right to notices and the making of submissions and appearances before Committees as well as fair treatment under all procedural and evidential rights.

Equality is achieved through the application of a common regulatory framework to all professions, despite their differences in scope of practice or their overlapping scopes of practice.
ACAP supports these views, and once the guidelines are promulgated, considers that all current and new applicants for regulation should have to abide by their application, noting the power of government to take unilateral action or over-ride other considerations in the public interest.

All applicants currently under consideration therefore should be given the opportunity to review their applications in the light of the final adopted guidelines.

**Discussion Point 11**

Do you have any other comments?

No

**Glossary**

The following terms are used in this submission.

- **ACAP**: Australian College of Ambulance Professionals
- **AHMAC**: Australian Health Ministers Advisory Council
- **COAG**: Council of Australian Governments
- **EMS**: Emergency Medical Services
- **HPCAA**: Health Professions Competency Assurance Act 2003 (NZ)
- **HPRAC**: Health Professions Regulatory Advisory Council (Ontario)
- **Paramedic**: A professional person whose education, training and skills enable them to provide a range of out of hospital emergency clinical procedures and medical care
- **RHPA**: Regulated Health Professions Act (Ontario)
- **UK**: United Kingdom