ASMS
ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
TOI MATA HAUORA

17 April 2025

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Tēnā koe Audrey

ASMS feedback on Putting Patients First: Modernising Health workforce regulation

As indicated in my letter dated 3 April 2025, Toi Mata Hauora (the Association of Salaried Medical Specialists) has significant concerns about the Ministry's consultation on modernising health workforce regulation. The consultation demonstrates limited understanding of New Zealand's health regulatory landscape and the health workforce. It also demonstrates limited willingness to genuinely engage with patients, the public, health practitioners, regulators, and other interested groups.

Internationally, there are a variety of models of health workforce regulation, with no single ideal model. All models come with risks and benefits that must be managed, based on the context of the health system in any particular country (1). When undertaking reform of the Health Practitioners Competence Assurance (HPCA) Act 2003, it is essential the reform is grounded in the New Zealand context, with evaluation and sound understanding of the need for reform, and the most effective options to achieve reform.

The current consultation provides little in the way of evidence or evaluation of how well health workforce regulation operates in New Zealand. It includes both errors of fact, and errors of omission. It also largely appears to be based on the assumption that health practitioners act in their own self-interest, with little regard for patients. Toi Mata Hauora refutes this characterisation. New Zealand has world class medical, nursing and allied health practitioners who go above and beyond to deliver high quality patient-centred care in challenging, resource-constrained circumstances every day.

The language used in the document also insinuates that health workforce regulation does not put patients first. This is incorrect - the primary purpose of the Health Practitioners Competence Assurance Act 2003 is to *"protect the health and safety of members of the public by providing mechanisms to ensure that health practitioners are competent and fit to practise their professions*." It is a key part of ensuring that patients receive safe, competent care. This core function of the Act is poorly explained in the document.

The consultation process is designed to limit engagement. We have been informed that written feedback (such as this letter) will not be analysed as part of the consultation process. Only responses entered into the Ministry's survey portal will be analysed, and the portal limits the scope of feedback that can be given. The consultation notes Artificial Intelligence will be used to analyse the responses. We are concerned that the use of Artificial Intelligence and lack of staff is therefore limiting the type

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of analysis that can be done to inform this critical regulatory reform. Artificial Intelligence should be used to enhance expert analysis, rather than to replace it.

We will be raising a number of these issues in a complaint to the Ombudsman, and as you know we have already highlighted preliminary concerns with the Public Service Commissioner.

Further feedback on the consultation is provided below. We request that this feedback is included in the Ministry's analysis of consultation feedback. We also seek a meeting with you to discuss our concerns in person.

Nāku noa, nā

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Toi Mata Hauora feedback on *Putting Patients First: Modernising health workforce regulation*

The consultation process is poor.

As highlighted above, the consultation process and document are of extremely poor quality. The document includes misleading and incorrect statements and limits the ability for genuine feedback. This undermines the stated goal of patient-centred regulation.

In particular:

- The consultation timeframe is short, and the consultation portal for providing feedback limits the type of feedback that can be provided.
- The document includes manufactured quotes that are phrased as though they are from patients. These are designed to elicit certain responses. The consultation does not explain that the quotes included are manufactured, giving the impression they are genuine quotes from patients. This is misleading.
- The questions are leading, when they should be open-ended and objective to elicit genuine feedback from patients, consumers, the workforce, regulators and other interested groups.
- The consultation is not based on evidence or data.
- Politicised language is used (e.g “bloated systems ”, “red tape and bureaucracy”). An objective, balanced analysis of how well workforce regulation is operating in New Zealand is absent.
- A Te Tiriti based analysis is totally absent from the document, and the document implies cultural factors are not relevant to clinical safety. This is incorrect.
- The document implies that health workforce regulation is the cause of New Zealand’s health workforce shortages. This is incorrect. The cause of workforce shortages is the failure to train sufficient numbers of health practitioners domestically over decades, high reliance on overseas trained practitioners, and poor retention of these practitioners.

Health practitioners in New Zealand care deeply about patients

Global reviews on health workforce regulation highlight that regulatory capture can be an issue, where standards are used as barriers to entry to the health labour market, favouring health practitioners rather than patients(1). However, this same review emphasises that no universally applicable, ideal model of regulation exists, and countries should regularly evaluate their approaches to health workforce regulation based on their local context.

We are concerned the current consultation insinuates that regulatory capture is occurring in New Zealand, and that workforce shortages arise because health practitioners involved in regulation are self-interested and set artificially high barriers to entering New Zealand’s health labour market for their own gain. This is incorrect and reflects a fundamental misunderstanding of New Zealand’s health workforce.

In the New Zealand context:

- Doctors have an altruistic code of practice and are governed by clear standards that the care of patients must be their first concern (2). Doctors are patient-facing, and experience first-hand the distress of not being able to meet patient needs due to entrenched workforce shortages.
- Workforce shortages negatively impact doctors working in New Zealand. Doctors experience burnout from heavy workloads and covering vacancies, and moral injury from not being able to meet patient needs. Setting artificially high barriers for entry into the workforce would not benefit doctors in New Zealand.
- Groups that represent doctors, including unions and medical colleges, consistently call on government to increase entry into the medical workforce (3). This includes advocating to increase the number of doctors trained domestically and recruited from overseas.
- In a predominantly publicly funded, and publicly provided system, workforce shortages have limited financial benefit for doctors. The Te Whatu Ora SECA sets a standard framework for remuneration for publicly employed senior doctors. Despite severe shortages, the salaries of New Zealand doctors remain far lower than international competitors for medical staff.
- In the last five years, almost 99 per cent of overseas trained doctors applying for registration in New Zealand, have received registration. Over the 5-year period, this equates to 4,333 overseas trained doctors who gained registration, and 53 who were declined (4). Of those declined, 13 were able to gain registration via an alternate pathway with the medical council. These numbers are not consistent with suggestions that barriers to entry are artificially high.
- The Medical Council recognises twenty-six different countries as comparable to New Zealand. Doctors from these countries can apply for registration via the Medical Council's Comparable Health System pathway.

Toi Mata Hauora is also concerned that the Ministry of Health's incorrect assumption that health practitioners benefit from health workforce shortages has inhibited meaningful, informed dialogue with health practitioner groups about reform of the HPCA Act 2003. Such an approach is counter-productive, prevents genuine engagement with the health workforce, and is unlikely to lead to fit-for-purpose workforce regulation. A more mature, evidence-based assessment is required.

Workforce regulation is not the cause of workforce shortages.

The consultation suggests regulation is to blame for New Zealand's health workforce shortages. For example, the consultation includes a quote *'I keep hearing about doctors from overseas who want to work here but can't. I know we need more doctors, why is it so hard?'*

We understand from the Ministry that this is not a real quote from a patient, but a hypothetical quote designed for the consultation. The document also suggests we are turning away skilled and experienced migrants. This is incorrect and misleading. The consultation contains no data on the volume of practitioners gaining registration in New Zealand each year, and the volume of applications declined.

New Zealand accepts high numbers of overseas trained doctors from a variety of countries (4). As described above, over the last 5 years, almost 99% of overseas-trained doctors applying for registration in New Zealand have received it. Of the handful of doctors declined initial registration each year, some have subsequently been able to gain registration through an alternative path.

New Zealand's health workforce shortages are caused by lack of resourcing, not regulation. For example:

- New Zealand has not trained enough medical practitioners domestically to meet its own needs for decades. We heavily rely on overseas trained doctors, with over 40% of our medical workforce made up of international medical graduates . Out of all OECD countries, New Zealand is only second to Israel in its dependence on overseas trained doctors (5). New Zealand must invest in training more doctors domestically, as soon as possible.
- New Zealand has poor retention of overseas trained doctors. Over 40% of overseas trained doctors leave New Zealand after one year, and 60% leave New Zealand after two years (6). New Zealand's main health workforce employer (Health New Zealand) must invest in retention initiatives to support doctors to stay in New Zealand. Currently, retention initiatives are ad hoc and employer support for overseas trained doctors can be poor.
- Since Health New Zealand was established, there have been hiring freezes due to budget constraints, which has impacted the recruitment and employment of doctors in New Zealand.
- Health New Zealand has a workforce plan that identifies the extent of medical workforce shortages, and the need to train more doctors domestically and recruit more internationally. However, that plan does not appear to be linked to Health New Zealand's budgeting process, meaning inadequate funding is provided to employ enough doctors to close the significant shortfall.

The most effective interventions to increase the numbers of doctors in New Zealand will not come from changes to the HPCA Act 2003. They could, however, be achieved by a financial commitment to train and employ more doctors in the health system, and recruit and retain more doctors from overseas.

Health practitioners on regulatory authority boards provide valuable, patient-centred expertise and experience

The consultation document suggests that although health practitioners understand the realities of a profession, their involvement as members of a regulatory authority should be limited as they may make decisions in their own best interests instead of in the best interests of the public. Once again, this analysis fails to recognise that doctors have an altruistic code of practice, and rigorous standards that require patient care to be their primary concern (2,7).

Regulatory bodies tend to include professionals with expertise in the field, alongside adequate checks and balances to manage any conflicts of interest. Including medical expertise on regulatory authorities supports patient-centred regulation in a number of ways:

- Doctors have altruistic codes of practice that require them to put patients first and speak up about what is best for patients. These standards mean doctors are less likely to be swayed by political pressure into taking decisions that are not in the best interests of patients. Evidence suggests that medical leadership within health organisations is associated with better patient care and health outcomes (8).
- Healthcare is complex and multi-faceted. Doctors have direct expertise and experience in providing patient care, from admitting patients, ordering tests, diagnosing, providing

treatment, prescribing, discharging patients, providing follow-up care, and liaising with other health practitioners and social services about patient care. Doctors have an in-depth understanding of the standards expected at each part of this process, including how patients are impacted when standards of care fall short.

- Limiting profession-specific involvement in regulatory authorities is likely to come at a cost for regulators. It will mean external health profession specific advice will need to be sourced by an alternative mechanism. This may increase costs through reliance on contractors, and slow-down decision-making processes.

Toi Mata Hauora welcomes the inclusion of consumers on regulatory authorities, alongside medical expertise.

The regulator must have independence from government

The consultation document states that "*regulators hold a significant amount of power in shaping the size of the health workforce, which can sometimes lead to worse outcomes for patients*."

No evidence is provided to support this claim, and Toi Mata Hauora considers the statement is incorrect. It is the government that holds the majority of power in determining the size of the health workforce, by determining the funding envelope for educating and training health practitioners, and employing staff in the public health sector. Poor workforce planning and lack of investment by government over decades has constrained the size of the health workforce, leading to significant unmet need for patients.

The consultation proposes that Ministers could have the ability challenge or override a regulator's decision. This would compromise the independence of the regulator from government, undermining patient-centred regulation. Enabling government Ministers to overturn or challenge the decisions of regulators will mean regulatory decisions become vulnerable to political pressure (for example to lower standards of care for political or financial reasons), compromising the purpose of regulation – which is public safety (9).

Consumer input

Toi Mata Hauora strongly supports patient-centred regulation. As described above, the principal purpose of the HPCA Act 2003 is already patient-centred. It is not clear from the consultation document which aspects of the legislation are not considered 'patient-centred'.

Public and health consumer engagement and input should be a key feature of health workforce regulation, and we note this already takes place. For example:

- The Medical Council of New Zealand shares a consumer advisory group with the Health and Disability Commissioner to ensure consumer input into strategy, policies, statements and professional standards. The group is called Whakawaha, and it includes members of the community with lived experience in mental health, disability, and addictions, as well as youth and older adult representatives.
- We are aware that medical colleges have consumer advisory groups with an active role in shaping medical education and policy initiatives, and that the Medical Council includes an expectation in its accreditation standards that medical colleges will involve health consumers when developing medical training programmes.

- At the time of this consultation, the Midwifery Council is consulting on the Midwifery Scope of Practice. The consultation is available on its website and is open for anyone to provide feedback on.
- Both the Medical Council and the Dental Council have consumer facing information on their websites, and easy to search registers of doctors and dentists.

Toi Mata Hauora has no concerns with further encouraging and formalising consumer input into health workforce regulation.

Cultural safety is clinical safety

Toi Mata Hauora has significant concern about the leading questions on cultural requirements in the consultation document that suggest 'cultural requirements' and understanding tikanga Māori are not related to clinical safety.

In New Zealand, Māori experience significant health inequities compared to non-Māori, including shorter life expectancy and poorer health outcomes across a range of indicators. Despite this, Māori also receive less access to healthcare, and poorer standards of care. For example, Māori receive lower levels of investigations and interventions than non-Māori, and fewer medicines prescriptions when adjusted for need (10).

Inequitable health outcomes for Māori is a significant quality and safety issue in New Zealand's healthcare system, and in international comparisons of health systems New Zealand ranks poorly for equity (11). In recent years, medical educators and regulators have been working to set standards and expectations of culturally safe care to improve outcomes for Māori. These standards (which require health practitioners to understand their own biases in providing care) benefit all patients – not just Māori.

Removing requirements for cultural competence and cultural safety will be harmful to patients and runs counter to the goal of patient-centred regulation.

The document also suggests regulators require cultural factors to be favoured when making hiring decisions. This is incorrect – regulators are not involved in hiring decisions at all. Hiring decisions are made by employers - such as Health New Zealand.

Deskilling the health workforce and lowering standards of patient care

In principle, Toi Mata Hauora has no problem with requiring regulators to think about how their decisions support safe innovation, and access to services for patients. However, health care is a high hazard, high-risk industry, and the primary purpose of the HPCA Act must continue to be protecting the health and safety of the public.

The consultation document suggests that regulatory reform could "unleash innovation and productivity within the health system." No evidence is provided for this statement, and the innovation suggested is to bring new practitioner groups such as physician associates and other "assistant" professions to New Zealand.

Relying on assistant workforces to make up the shortfall of doctors, nurses and allied health professionals poses significant risks for patients. Assistant workforces have substantially lower levels of training than the workforces they assist and are not be able to fill shortages of existing professions

such as doctors and nurses. The “innovation” suggested in the consultation is to increase the number of people employed in the health workforce, by lowering standards and training requirements.

Physician associates have been introduced in the United Kingdom, which has generated significant controversy, and has resulted in the Secretary for Health and Social Care establishing an independent review into the profession. The safety and efficacy of the physician associate role remains highly contested, with evidence suggesting physician associates struggle in settings such as primary care, with autonomous roles, diverse case-mix, uncertainty, and challenging supervision arrangements (12).

Recently, the British Medical Association published a report documenting over 600 concerns from doctors about the practice of physician associates. These included making incorrect clinical decisions in place of doctors; introducing themselves to patients as doctors; dangerously prescribing medication, and taking part in surgical procedures they were not qualified to do. The report also suggests physician associates are inappropriately used in place of doctors to fill roster shortages, despite not having the skill and training to fulfil such roles (13).

Concerns occurring in the United Kingdom are likely to arise in New Zealand also, and include risks to patient safety; lack of evidence for clinical effectiveness; lack of clarity about tasks physician associates can safely undertake and at what level of supervision; lack of transparency and informed consent for patients; reduced training opportunities for junior doctors; and additional workload for doctors charged with supervising a new workforce (12).

Toi Mata Hauora considers that proposals to bring in assistant workforces are an attempt to lower standards of patient care, to increase the size of the health workforce. It is our position that the size of the health workforce must be increased, and standards of patient care maintained at the same level. As described above, this can be achieved by investing in training and recruiting more doctors, nurses and allied health practitioners in New Zealand.

A recent Health New Zealand review of clinical quality and safety over the last 10 years found that there are significant barriers to accessing care, but once people access care, the majority have a positive experience, and trust in New Zealand health care professionals is very high (14). This indicates that New Zealand’s health workforce regulation is working as intended and patients are receiving a high standard of care. Increasing the number of doctors, nurses and allied health practitioners working in the system would increase access, without compromising standards of care.

Other opportunities for regulatory reform

The HPCA Act 2003 is overdue for review, and Toi Mata Hauora encourages the Ministry of Health to engage in mature, open dialogue with the public, health practitioners, and regulators on the review.

In principle, Toi Mata Hauora would support some suggestions contained in the consultation, such as introducing a second tier of regulation outside of the HPCA Act 2003 for professions that pose a lower risk to the general public (for example, an accredited register model as used in the United Kingdom).

Toi Mata Hauora urges the Ministry to develop more specific proposals for consultation and discussion.

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