Putting Patients First:

Modernising health workforce regulation

NZSTA submission April 2025

Patient-centred regulation

1. Would you be interested in having a say on any of the following?

☒Changes to scopes of practice (what health practitioners can do) and how this affects patient care

☒Qualification requirements

☒Other professional standards (for example, codes of conduct) that impact patient experience

2. Are there any other things you think the regulators should consult the public on?

This question implies that regulators should consult the public about changes to scopes, qualification requirements, and professional standards as listed in question 1.

While we recognise the value of a public voice in shaping a responsive, transparent, and people-centred health system, under the HPCAA, avenues for the consumer voice exist with laypersons on each responsible authority (RA).

We have serious concerns about uninformed or unbalanced public influence over regulatory decisions relating to:

- Scopes of practice
- Qualification requirements, and
- Professional standards (e.g., codes of conduct)

These highly technical domains require in-depth professional, clinical, and cultural expertise. The key risks of opening these decisions to general public input include:

Risk of undermining clinical safety and quality
Regulatory frameworks must protect the public by ensuring practitioners are competent, ethical, and safe. While valuable, public opinion may be based on perception or anecdote rather than evidence. There is a real risk of:

- Pressure to expand scopes of practice beyond safe limits.
- Calls to lower qualification thresholds to address workforce shortages.
- Over-simplification of clinical responsibilities and ethical obligations.

Risk to culturally safe care and Te Tiriti o Waitangi obligations
Public consultation processes often fail to reflect the voices of Māori, Pacific peoples, disabled communities, or those most affected by health inequities. If these voices are not proactively and equitably included, public consultation can:

- Dilute culturally responsive standards, such as requirements for understanding tikanga Māori.
- Privilege dominant perspectives that do not represent the diversity of Aotearoa's health consumers.
- Undermine efforts to embed the Tiriti partnership in regulation and professional expectations.

Risk of politicisation or populism
Highly visible or controversial decisions (e.g., scope expansion, disciplinary matters) could become politicised. Regulators may be swayed by popular opinion rather than prioritising public safety or long-term system needs.

Risk of eroding profession-specific knowledge
Those with the training, clinical knowledge, and lived experience develop professional scopes and qualifications. While necessary for identifying unmet needs or concerns, public input should not override the judgement of qualified professionals and regulators.

Our recommendation
We support targeted, informed, and equity-focused consultation, especially where decisions affect consumer experience or access. However, decisions about scopes, qualifications, and standards must be led by those with:

- Professional expertise
- Health equity knowledge
- A commitment to Te Tiriti o Waitangi

Public voice must inform regulation — but it cannot replace professional responsibility, clinical judgement, or cultural accountability.

3. Are there any health practitioners who are currently unregulated but should be subject to regulation to ensure clinical safety and access to timely, quality care?

We offer a qualified response to this question, noting the underlying assumption that statutory regulation is a direct lever for improving access to timely, quality care. In reality, regulation primarily exists to protect public safety and uphold professional standards — it has limited influence on access, which is more directly shaped by workforce planning, funding models, and service delivery structures.

Secondly, the proposal's current wording implies that medicalised procedures (e.g., surgery) carry a higher risk of harm and therefore should be regulated, and that other areas pose less risk and do not need to come under the regulator's purview. This approach does not take into account the significant known psychosocial and financial harm to individuals and families that can occur from poor practice. Regulation should seek to protect individuals and whānau from harm in all its forms. Similarly, an "adverse outcome" should include detrimental effects on psychosocial and financial health.

NZSTA would advocate for a transparent and comprehensive risk assessment framework.

In the case of speech-language therapists (SLTs) who self-regulate through the NZSTA, there is a live discussion within the membership, with mixed views. Some argue for regulating SLTs, while others contend that the diversity of practice settings and the current strength of self-regulation suggest that mandatory statutory regulation may not necessarily be warranted. However, we acknowledge that this remains a live discussion and any future proposal would require careful consultation with the profession, the public, and our Tiriti partners.

Any future decision for NZSTA to pursue regulation under the HPCAA or other regulatory format will be guided by:

- The actual risk of harm to the public
- The adequacy of current self-regulatory mechanisms
- The profession's readiness and desire for statutory regulation

- The equity implications, particularly for Māori and whānau Māori
- The potential costs, benefits, and unintended consequences of regulation

4. Do you think regulators should do more to consider patient needs when making decisions?

☒ **Yes**

☐ **No**

5. What are some ways regulators could better focus on patient needs?

Responsible authorities under the Health Practitioners Competence Assurance Act (HPCA) 2003 have a statutory duty to protect the health and safety of the public. While some already incorporate public perspectives and consumer representation, there is significant potential to strengthen their focus on patient needs, experiences, and equity.

We suggest the following ways regulators could improve:

1. Strengthen accountability to Te Tiriti o Waitangi and health equity

- Patient needs must be understood through the lens of equity, particularly for Māori, who experience persistent health inequities.
- Responsible authorities should be explicitly required to give effect to Te Tiriti o Waitangi, aligning with the direction of the Pae Ora (Healthy Futures) Act.
- This includes ensuring that cultural safety is part of competence and recertification standards, as already implemented by some authorities, such as the Medical Council and Nursing Council.

2. Embed diverse patient voices in governance and decision-making

- Currently, most responsible authorities are profession-dominated, with only one or two lay members.
- To better reflect patient perspectives, authorities could:
    - Increase the number and influence of consumer and whānau representatives on their boards.

- Support the establishment of consumer advisory groups with clearly defined roles to inform, but not determine, decisions on scopes, complaints, and standards of practice.
- Ensure Māori and Pacific consumer voices are intentionally included, not just consulted.

3. Make regulatory information accessible and patient-friendly

- Many patients are unaware of how to:
  - Check whether a practitioner is registered
  - Raise a concern or complaint
  - Understand the scopes of practice or competence standards
- Authorities could:
  - Redesign websites and public information using plain language and multiple formats, including te reo Māori and accessible formats.
  - Run public awareness campaigns about their role and the rights of health consumers.

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4. Use patient experience to shape standards and practice expectations

- Feedback from patients and whānau (e.g., through complaints, ACC reports, HDC findings) should inform:
  - Codes of conduct
  - Communication and cultural safety standards
  - Competence and recertification frameworks
- Some authorities already require reflective practice and cultural safety – this should become universal and enforceable.

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5. Monitor and report on how regulation impacts access and equity

- While regulation does not control service delivery, it does influence:
  - Who can practise
  - Where and how they can practise
  - How easily overseas-trained professionals can enter the workforce

- Responsible authorities should:
    - Report publicly on how their decisions affect workforce access and distribution.
    - Collaborate with health system agencies to ensure regulation supports service equity and innovation.

These suggestions, if implemented, come at a cost—there is a case for the Government providing funding for increasing the consumer voice and not expecting the individual practitioners to bear the cost.

6. What perspectives, experiences, and skills do you think should be represented by the regulators to ensure patients' voices are heard?

We support a balanced representation model that integrates clinical expertise with consumer, cultural, and equity perspectives to ensure that regulators under the HPCA Act are responsive to patients while upholding safe, competent care.

It is essential that patients' voices are genuinely heard, but not at the expense of profession-specific insights that are critical to protecting public safety.

Regulators must strike a careful balance between profession-specific expertise and public voice.

- A majority of profession-specific members are essential to ensure scopes of practice, qualifications, and standards are safe, evidence-based, and practical.
- Consumer and whānau perspectives ensure the system reflects real-world access, communication, and cultural safety needs.
- Māori representation and Tiriti-based partnerships are critical to honouring Te Tiriti o Waitangi and improving outcomes for Māori.
- Voices representing equity, disability, and rural health could also be included to reflect Aotearoa's diversity.
- There needs to be clear eligibility criteria for lay persons so that they can contribute meaningfully to regulatory decisions.

A well-balanced regulator brings these perspectives together in a collaborative, co-governed model, ensuring that decisions are clinically safe, culturally responsive, and patient-focused.

Note: Should the government mandate greater layperson representation on responsible authorities, NZSTA expects central government to fund the additional administrative costs this entails.

7. Do you agree that regulators should focus on factors beyond clinical safety, for example mandating cultural requirements, or should regulators focus solely on ensuring that the most qualified professional is providing care for the patient?

☒ Yes, regulators should focus on factors beyond clinical safety, for example, mandating cultural requirements

☐No, regulators should focus solely on ensuring that the most qualified professional is providing care for the patient

The framing of this question is misleading and reflects a limited understanding of what clinical safety entails. Cultural competence and safety are not peripheral to care — they are central to high-quality, equitable, and effective healthcare delivery.

Cultural competence requires practitioners to reflect on how their cultural background, alongside that of the individual receiving care — shapes the clinical relationship and influences outcomes. It is not about treating people "regardless of difference" but rather "in full regard of difference" (Curtis et al., 2019). Culture in this context encompasses ethnicity, gender, sexual orientation, socioeconomic status, disability, and religious or spiritual beliefs.

Cultural competence is a core capability—not a "nice to have"—for the speech-language therapy profession. A competent clinician is a culturally safe clinician.

This is not merely professional opinion but embedded in law, policy, and regulation. Cultural competence is mandated under:

Section 118(i) of the Health Practitioners Competence Assurance Act 2003, which requires Responsible Authorities to set standards of cultural competence;

Right 2 of the Code of Health and Disability Services Consumers' Rights, which affirms every consumer's right to be treated with respect, including respect for their cultural identity, values, and beliefs;

This is reinforced in the Government Policy Statement on Health 2024–2027, which prioritises a culturally competent workforce as a critical enabler for improved health outcomes and equity.

For NZSTA, culturally safe practice is not an abstract value — it is embedded in our Code of Ethics, education and qualification and continuing professional development frameworks. It enhances the therapeutic alliance, improves clinical decision-making, and ensures people feel heard, respected, and empowered in their care.

If this consultation aims to promote patient-centred regulation, cultural competence and safety must remain regulatory priorities.

References:

Brewer, K. M., & Andrews, W. (2016). Foundations of equitable speech-language therapy for all: The Treaty of Waitangi and Māori health. *Speech, language and hearing*, *19*(2), 87-95.

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S. J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International journal for equity in health*, *18*, 1-17.

8. Do you think regulators should be required to consider the impact of their decisions on competition and patient access when setting standards and requirements?

☐Yes

☒No

Streamlined regulation

1. How important is it to you that health professions are regulated by separate regulators, given the potential for inefficiency, higher costs, and duplication of tasks?

Very important

Important

Moderately important

Slightly important

Not important

Why?

Separate regulators can be important where a profession's risks, scopes of practice, cultural context, and workforce pathways are distinct. However, we also recognise the need for efficiency, sustainability, and better collaboration across the regulatory system.

Why separate regulation can be important:

- It ensures that profession-specific knowledge and risk profiles shape scopes, standards, and competence expectations.
- Smaller professions, such as speech-language therapy, risk becoming invisible or misunderstood within broader regulatory structures, especially when they are merged with unrelated disciplines.
- Regulation should support diverse practice settings, including health, education, justice, disability, and hauora Māori contexts, which may not align easily with generalised approaches that consider the health sector alone.

But we also acknowledge:

- The current system is fragmented, and some duplication (e.g. IT systems, processes) could be reduced.
- Shared infrastructure, joint committees, cross-regulator collaboration and consistent application of standards and ethical practice across professions could improve efficiency without sacrificing autonomy.
- Some smaller regulators struggle with resourcing, consistency, or responsiveness, especially when under strain.

Our position:

We value profession-specific regulation, especially for professions with distinctive scopes and public-facing roles, such as SLTs. However, we support exploring shared services or a federated model that retains professional identity while improving consistency and reducing cost.

Any changes must be co-designed with the professions, Māori, and the public and must protect public safety and professional voice.

2. To help improve efficiency and reduce unnecessary costs, would you support combining some regulators?

☒Yes

☐No

Comment:

We support exploring smarter, more collaborative models, but we are cautious about full amalgamation, particularly where it may compromise professional identity, cultural safety, or tailored regulation.

What we would support:

Shared services or back-end functions (e.g. IT systems, finance, administration) across multiple regulators, after a thorough cost-benefit analysis.

Joint working groups to align standards where appropriate (e.g., cultural safety and complaints processes).

Collaboration that retains profession-specific governance and decision-making while reducing duplication.

What we would not support (without strong safeguards):

Blanket merging of regulators into large, generic authorities, especially where smaller professions like speech-language therapy could become marginalised.

Loss of sector-specific oversight in areas like education, disability, justice and early intervention, which are central to many SLT roles but peripheral in other health professions.

Bottom line:

Efficiency is important — but not at the cost of public safety, equity, or professional relevance. Any changes must be consultative, Tiriti-consistent, and carefully assessed for unintended consequences. We urge learning from international experience, such as in the United Kingdom – Health and Care Professions Council (HCPC) and the Australian Health Practitioner Regulation Agency (AHPRA)

Reference: Adams, T. L. (2022). Amalgamation of Professional Regulators: Conflicting Perceptions and Beliefs Among Canadian Regulatory Leaders. *Journal of Nursing Regulation*, *13*(2), 25-33.

World Health Organization. (2024). Health practitioner regulation: Design, reform and implementation guidance, 9 September 2024. Retrieved on 17 April 2025 https://www.who.int/publications/i/item/9789240095014

Right-sized regulation

1. Do you agree that these regulatory options should be available in addition to the current registration system?

Accreditation

☒Yes

☐No

Credentialling

☒Yes

☐No

Certification

☒Yes

☐No

Any other options

We support the availability of alternative regulatory options, *in addition to*, not as a replacement for, the current statutory registration system. These tools may be appropriate for certain health professions or scopes of practice where the risk to public safety is lower or where regulation under the HPCA Act may be disproportionate. However, refer to question 3 under Patient-centred regulation, where we argue that risk is not just physical, so regulation should seek to protect individuals and whānau from harm in all its forms.

Why we support these options (in principle):

- **Accreditation** could provide an effective framework for recognising the role of professional bodies (like NZSTA) that already operate with high standards and accountability. It is hoped that this will enable title protection and other statutory powers.
- **Credentialling** offers flexibility within workplaces and health services, especially with strong local clinical governance structures. NZSTA already operates credentialing in specific competency areas, such as videofluoroscopy swallowing studies, supported via Te Whatu ora.
- **Certification** can support the safe expansion of specific skill sets (e.g., vaccinators) where micro-qualifications or targeted training is appropriate.

But we emphasise caution:

- These models must not create a **two-tier system** that undermines the safety, credibility, or development of professions like speech-language therapy.
- They must not be used to **sidestep the regulation of professions** that work with vulnerable populations or undertake higher-risk procedures.
- Oversight, cultural safety, and public trust must be **explicitly built into each model** — especially in Aotearoa where Te Tiriti o Waitangi and equity are foundational.

Additional Comment: Ensuring consistency through risk-based reassessment of all professions

We strongly recommend that any new framework for alternative regulatory models (e.g., accreditation, credentialling, certification) be accompanied by a transparent, profession-wide risk assessment process that identifies and evaluates the potential harms associated with each profession's scope of practice, service context, and level of autonomy—ensuring regulatory approaches are applied consistently and proportionately across the health workforce..

At present, many professions are included in the HPCA Act by historical default, not necessarily because of an up-to-date assessment of risk to public safety.

Why this matters:

- If unregulated professions are expected to meet new criteria to justify their inclusion in statutory regulation, then currently regulated professions should be subject to the same level of scrutiny.
- This ensures a level playing field, avoids perceived or actual bias, and supports a more rational, proportionate regulatory landscape.
- It would also allow streamlining or adjusting regulatory models where a full statutory regime may no longer be proportionate or necessary for existing professions within the HPCAA.

Our recommendation:

A consistent, evidence-based risk assessment framework should be applied across all health professions — regulated and unregulated — to determine:

- The level of clinical risk posed by the profession’s typical scopes of practice
- The settings in which the profession operates (e.g. unsupervised, vulnerable populations)
- The existing mechanisms for accountability and oversight
- The impact of regulation (or lack thereof) on access, equity, and patient outcomes

This could lead to a recalibration of which professions are:

- Best suited for full HPCA regulation
- Appropriately managed through alternative models
- Adequately supported through co-regulation or employer-based credentialling

2. Do you think New Zealand's regulatory requirements for health workforce training, such as the requirement for nursing students to complete 1,000 hours of clinical experience compared to 800 hours in Australia, should be reviewed to ensure they are proportionate and do not create unnecessary barriers to workforce entry?

☐Yes

☒No

3. Should the Government be able to challenge a regulator's decision if it believes the decision goes beyond protecting patient health and safety, and instead creates strain on the healthcare system by limiting the workforce?

☐Yes

☒No

The question assumes that regulators are creating unnecessary barriers to workforce entry, but clear, system-level evidence for this claim is lacking.

- Most regulators have already established processes to assess qualifications and competence, particularly for practitioners trained overseas.
- Delays or declined applications often reflect legitimate concerns — such as ensuring clinical safety, language proficiency, or recency of practice or incomplete applications — not gatekeeping.
- Where is the public data showing that regulators are a primary cause of workforce shortages?

In reality, workforce constraints are driven by multiple system-level factors, including the capacity of the education pipeline, immigration policy, service funding, and retention challenges.

If the Government believes regulation is contributing to workforce issues, it should provide transparent evidence and engage with regulators to improve alignment — without compromising public safety or regulatory independence.

We understand the Government's interest in addressing workforce shortages and ensuring regulation does not create unnecessary barriers. However, we do not support giving the Government the power to unilaterally override or challenge individual regulator decisions for the following reasons:

Independence of regulators is critical

- The HPCA Act was designed to ensure that regulatory authorities act in the **public interest**, independent of political influence.
- Allowing the Government to intervene risks **politicising decisions** that should be based on professional standards, clinical risk, and ethical integrity.

Protecting public safety and professional standards

- Regulators make decisions based on the competence, conduct, and risk to the public of practitioners. These decisions must prioritise safety, even if they temporarily constrain workforce numbers.
- Overriding such decisions could erode public trust, especially if workforce growth is prioritised over safety or quality.

We support exploring **more transparent mechanisms of accountability**, such as:

- Requiring regulators to publish rationales for decisions that significantly affect workforce supply.
- Strengthening health system alignment (e.g., via Memoranda of Understanding or joint advisory groups) to ensure regulators consider system impacts *without compromising their independence*.

We agree that regulators should be aware of and responsive to workforce pressures, but this must not come at the cost of safe, competent, and culturally appropriate care. The Government should guide and support regulatory decisions, not direct or override them.

4. Do you support the creation of an occupations tribunal to review and ensure the registration of overseas-trained practitioners from countries with similar or higher standards than New Zealand, in order to strengthen our health workforce and deliver timely, quality healthcare?

☐Yes

☒No

Is the current system actually broken? Or is it being mischaracterised? What evidence suggests that the current system is flawed?

Responsible authorities and self-regulators already have established evidence-based processes for registering health practitioners, including those trained overseas. In the case of speech-language therapy we also have a Mutual Recognition Agreement with five other English speaking jurisdictions. These processes are designed to protect public safety, ensure clinical competence, and maintain professional standards.

Clarity in policies regarding qualification equivalency, recency of practice, language proficiency, and the appeal process may be needed, as well as better data on why applications are declined or delayed.

5. Should the process for competency assessments, such as the Competence Assessment Programme (CAP) for nurses, be streamlined to ensure it is proportionate to the level of competency required, allowing experienced professionals who have been out of practice for a certain period to re-enter the workforce more efficiently, while still maintaining clinical safety and quality of care?

This question is very specific, and although it uses the CAP for nurses as an example, it's framed in a way that assumes all professions face the same barriers or processes. It could unintentionally narrow the discussion to nursing-specific issues when the broader goal is to consider right-sized regulation across all health professions. I wonder if the correct question is: "Should competency assessment and return-to-practice processes across health professions be reviewed to ensure they are proportionate to the level of risk, while still maintaining public safety and professional standards?"

As for the previous question, is the system broken? Is there evidence that competency assessments are disproportionate to the level of risk?

6. Do you believe there should be additional pathways for the health workforce to start working in New Zealand?

This question appears to duplicate earlier consultation themes. We support reviewing and improving workforce entry pathways where needed — but reiterate that any new routes must maintain public safety, uphold cultural competence, and reflect Aotearoa's unique health context.

Our workforce issues are not the result of a lack of pathways, rather a lack of investment in training and in jobs. New Zealand currently has 20 speech-language therapists per 100,000 head of population(HoP) compared to Australia which sits at 42 per 100,000 HoP. Increasingly our new graduates leave immediately on qualifying for employment overseas as we lack suitable graduate positions.

Reference:

The case for building the speech-language therapy workforce capacity: We need more SLTs

Future-proofed regulation

1. Do you think regulators should consider how their decisions impact the availability of services and the wider healthcare system, ensuring patient needs are met?

Yes — regulators should consider how their decisions impact service availability and workforce capacity, but not at the expense of public safety, professional integrity, or equity.

Their core role remains to protect the public through competence and ethical standards. However, they can and should:

- Work in closer alignment with system-level priorities, including health workforce planning and equitable access.
- Report on the downstream impact of major regulatory decisions, especially those affecting scopes of practice, entry requirements, and return-to-work pathways.

- Maintain independence while being responsive to the wider health system's needs — including those of Māori, rural communities, and underserved populations.

2. Do you think the Government should be able to give regulators general directions about regulation?

We support the Government setting high-level expectations for regulators — particularly around areas like equity, Tiriti obligations, and system alignment — but we do not support direct intervention in operational or profession-specific regulatory decisions.

Regulator independence is essential to maintaining public trust, professional credibility, and clinical safety.

The Government can already influence direction through:

- The Government Policy Statement on Health
- Legislative reform
- Sector-wide priorities and funding

3. Do you think the Government should have the ability to appoint members to regulatory boards to ensure decisions are made with patients' best interests in mind and that the healthcare workforce is responsive to patient needs?

☐Yes

☒No

The Government already appoints members to regulatory boards under the HPCA Act, including lay members intended to represent the public interest.

We support maintaining this role, provided it is:

- Transparent (which currently it is not)
- Tiriti-consistent (with Māori appointments made in partnership)
- Designed to ensure balanced representation — including profession-specific, consumer, equity, and system-level perspectives.

Any suggestion of expanding this power should be approached with caution to protect regulator independence, avoid politicisation, and uphold public trust.