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You do not have to answer all the questions or provide personal information if you do not want to.

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Position (if applicable):		Executive Director

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Submission on the 2012 review of the Health Practitioners Competence Assurance Act 2003 (HPCA Act)

By the Council of Medical Colleges (CMC)

This submission is sent on behalf of eight Member Colleges of the CMC who broadly support the points made in this joint CMC submission. Some Colleges will also be making their own, independent submission with emphasis on other points of importance to their particular College.

Introduction

The Council of Medical Colleges in New Zealand (CMC) is the collective voice for the Medical Colleges in New Zealand and through its members, provides a well trained and safe medical workforce serving the best interests of the New Zealand community.

CMC brings together 14 member Medical Colleges who provide support to over 7000 specialist medical practitioners working in a range of 35 specialties in the New Zealand health system. The Medical Colleges themselves are not-for-profit, educational bodies responsible for the training and examination of medical practitioners. The Medical Colleges advise on workforce issues and advocate for appropriate health quality services in New Zealand. They also advise the Medical Council of New Zealand in relation to standards for training and qualifications of specialist doctors from overseas and provide programmes of continuing medical education or recertification as defined by the (HPCA Act).

It is noted that the time line to respond to this review is short, which limits input as it takes time for the Colleges to consult their constituency groups and prepare a submission.

In addition notice about the HPCA Act consultation meetings was inadequate as demonstrated by low attendance in Wellington.

It is also noted that the issues and questions in the separate sections of the submission document overlap and are not always aligned which makes response difficult. Therefore this submission addresses the issues rather than answers all the questions and CMC comments may apply to more than one section of the consultation document.

It is also noted that many of the points raised in this document were noted in the 2008 HPCA Act review and that a more thorough implementation of those recommendations at that time may have enabled this review to address other issues and have the information to assess the efficiency and effectiveness of the Responsible Authorities (RAs).

Overall comments

This response to the HPCA Act review primarily addresses issues that impact on CMC's members and their constituencies, that is the impact on vocationally registered or specialist doctors and doctors in specialty or vocational training.

CMC does agree with many things in the scope document such as the following:

- Focus the sector towards better, sooner, more convenient service delivery through the integration of primary care with other parts of the health service and to retain a workforce that delivers services within a lower growth funding.
- Improve pastoral care for the health and welfare of health professionals and support for the sustainability of the workforce.
- Improve/ develop cross sector data collection systems to inform sector intelligence and planning.

However, CMC does not see that a change in the HPCA Act is needed to deliver on all these principles and many of the matters suggested may take emphasis away from the purpose of the HPCA Act.

CMC notes that the main purpose of the HPCA Act is to *"protect the health and safety of members of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions"*.

To enable this purpose to be met, the mechanisms regulators use are to:

- Assess **who gets onto the register** - ensuring those that are registered are fit and competent to work.
- Assess **who stays on the register** so the public can trust that those on the register are able to practise safely and maintain their competence.
- Agree on **who are removed from the register** for long or short periods because they have shown to be wanting in competence, or have been practising below the required standard or are not able to practise due to ill health.[1]

Therefore the HPCA Act (in common with similar health professional and occupational regulation world-wide) is essentially about regulation of the individual for public protection.

This relatively limited role is supported by other legalisation and regulations within the sector and by employment contracts and by a myriad of guidelines and standards in health which set other standards and ways of working for those providing services in the health sector.

The consultation document seems to be suggesting a move away from the clear purpose of the HPCA Act but there is little evidence in the consultation document:

- To indicate that the concerns or issues raised are caused by the HPCA Act.
- On how changes in the HPCA Act could lead to improvements in the working of the health sector.

The emphasis of the HPCA Act must be on safety, prevention and competence.

While operation of the HPCA Act and operation of the responsible authorities (RAs) can be improved, CMC's perspective is that HPCA Act is currently achieving its purpose and a rationale for radical change has not been given.

[1] Thompson, E. *Understanding medical regulation – a guide to good practice*. HLSP Consulting 2005

1. Future focus

1.1 Workforce development and the purpose of the HPCA Act

CMC supports the current HPCA Act functions which require the Medical Council (and other RAs) to set the standards for educational, training and competence for safe practice; that is assess **who is safe to include on register** and assessing who is competent to **stay on the register.**

Sections 13 (a), (b) and (c) of the HPCA Act already note that the "standard to be set" by the RA is to protect the public, and not to unnecessarily restrict registration or impose undue cost on applicants for registration. Therefore the HPCA Act sets a safe standard not a "gold standard".

CMC does not accept that it is better for the public to have a "doctor of a lesser standard" than not to have a doctor, as the former gives the public unsafe expectations.

Therefore as standard setting bodies, the RAs cannot then "develop" or "increase" the workforce as this function conflicts with their standard setting role. Workforce numbers could be increased by lowering the acceptable standard but this would conflict with the purpose of the HPCA Act 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*".

Planning and achieving workforce development is the role of other groups including that of Health Workforce New Zealand (HWNZ).

1.2 Health practitioners working in teams

The HPCA Act has a focus on the competence on the individual practitioner but this does not does not mean that the role of the practitioner cannot change and the HPCA Act framework cannot support workforce flexibility and working in multidisciplinary teams.

Effective multi-disciplinary teams and flexibility cannot be regulated for by a statute. Health teams are diverse in size, function and structure and are dependent on the specific health setting and the employment situation. Good teams function where there is the right environment and culture supported by management: not because of legislative requirements.

Currently in medicine and within the HPCA Act, team work is already supported because:

- The Colleges **include education and training about team-work and communication** as an integral part of their specialty training programmes.There is explicit guidance on working within teams in the RA documents of standards expected of the health professionals regulated by the HPCA Act. In medicine it is supported by the Medical Council's standard setting document *Good Medical Practice.*

Other sector documents encourage team work such as:

- The Code of the Health and Disability Commissioner (HDC) which states that *"every consumer has the right to co-operation among providers to ensure quality and continuity of services"* and breach of the Code can be acted on by the HDC or the Medical Council.
- Employment contracts and expectations of most health providers.
- The work and commitment of the majority of health professionals.

CMC recommends that a more explicit focus on inter-professional communication and collaboration could be introduced into the HPCA Act:

- By adding to the functions of the RAs in Section 118(j) by requiring RAs: *to liaise with other authorities appointed under this Act about matters of common interest* ***including setting scopes of practice that do not limit integrated models of care or intra-professional cooperation and that encourage team work.***

1.3 Scopes of practice

The consultation document indicates there is a breakdown in cooperation between some team members due to concerns about practitioners rigidly adhering to defined scopes of practice. This leads to a lack of flexibility in the workforce. However there are no examples of these practises in the document.

Scopes of practice do and have always overlapped. As the sector has grown and developed new scopes, new areas of work and new roles are continually being developed. This should continue.

Scopes have been developed primarily for the professions and the providers to identify the health service being provided and health services that the practitioner is permitted to perform, subject to any conditions imposed by the responsible authority. The public require a different level of information.

1.4 Information in scopes of practice and workforce flexibility

CMC recommends that, following this review of the HPCA Act, all RAs are requested to review their scopes of practice with wide sector consultation, within a template supplied by the Ministry of Health (so that there is not the current disparity between lack of detail/excess detail).

When scopes were originally introduced under the HPCA Act in 2003/4, there was little experience with the concept and although the sector was consulted about the scopes as required by the HPCA Act, there was very little input from groups such as employers and non regulated health professionals. The core scopes were all laid down at that time and only a few new ones have been developed since.

Now some 10 years later, the sector will be more aware of any actual concerns or limitations resulting from scopes of practice (as opposed to individual practitioner's interpretation, which is not reinforced by the RA or the scope).

If during this review there is **evidence of wide spread restrictive practice,** then the RAs should be required to address this and there is a mechanism to do this under Section 127.

HWNZ also needs to assess whether scopes are developed to assist define areas of practise so providers, employers and RAs can assess competence to practise within a scope or whether scopes are to inform the public. The two "audiences" are different and require a different approach and level of detail.

1.5 Improving pastoral care

It is recognised that health practitioners need assistance when going though the RA processes of competence and complaints and that these are stressful for the practitioner. However these processes are coordinated by the RA and it is inappropriate for the RA to offer assistance as the practitioner goes though the processes.

Other events also impact on health practitioners and can be stressful and may lead to health concerns. The RAs' functions include in Section 118 (h); *to consider the cases of health practitioners who may be unable to perform the functions required for the practice of the profession.*

The result of this consideration may lead to medical assessment, suspension and conditions on or loss of practising certificate. These functions are totally at variance with providing increased pastoral care. A person is not going to seek RA help if they know this may impact on their ability to practise.

Currently many RAs including the Medical Council, do use voluntary agreements so that they can assist practitioners who are ill or unfit to practise without using the disciplinary aspects of the HPCA Act in an effort to increase reporting in this area. That said it is widely accepted that under-reporting does exist because, while the Medical Council and other RAs try to take a rehabilitative approach, they have to operate within statute that is protecting public safety first and caring for the doctor second.

A better solution in this area would be to set up a non statutory group to work with practitioners, providing pastoral care and support or work with groups who already fulfil this role within the sector such as the Colleges. A non statutory group would then only report to the RA when a matter is likely to impact on public safety. **Thus separating the roles and functions of legal enforcement and pastoral care.**

This type of group operates in several states of the United States, working on a confidential basis to assist the doctors. The principle is that "sick" doctors are more likely to self refer or be referred by peers or family if there is no fear of losing the right to practise. The argument is that this will increase referrals and improve the possibility of rehabilitation so that in turn the public is protected. Such a group would also be able to provide pastoral care to those going though other RA processes i.e. complaints and competence concerns.

Such a group if operated in New Zealand, could assist all groups of health professional covered by the HPCA Act and could also work with other professionals where health may impair practice such as airline pilots, lawyers, accountants and engineers.

Another approach is to set up an arm's length group such as in the United Kingdom with National Clinical Assessment Service which improves patient safety by helping to resolve concerns about the

professional practice of doctors, dentists and pharmacists in the UK and overseas.

2. Consumer focus

2.1 Public understanding and public involvement

The 2008 review of the Act recommended that *responsible authorities and the Ministry of Health do more to inform the public about the Health Practitioners Competence Assurance Act 2003 through their websites, publications and other means, including making business information about registered practitioners freely availabl*e.

Some four years later, apart from improved RA websites, there is no great change.

The public need to understand the functions of the RAs when a member of the public has a concern about a health practitioner's practice and this is often facilitated by the Health and Disability Commissioner and HDC advocates. Transparency of matters such as the complaints process for regulated groups far exceeds the transparency of the processes for non regulated health groups.

However improvements can always be made to public **health literacy**.

CMC suggests public understanding of the health sector would be enhanced by **better title protection**[2] and increased clarity in relation to Section 7 of the HPCA Act so that the public are clear on the status and education and training of those treating them.

The paper confuses the role of lay people on the RA board and input by consumers or users of health services.

A lay person is appointed to an RA board to be part of the governance group and therefore needs governance skills. They also represent "public interest" and may balance the views of the professional who may focus on the professions' interests.

A consumer is someone who uses services (in this case health) and who may be able to give input to the RA development of codes, guidelines and scopes. Thus it would be an advantage in New Zealand to have an external forum made up of people who could give a view on matters proposed by the RAs and many other groups across the health sector.

Several Colleges and the Medical Council already involve the public in their decision making and policy development through consumer forms. This work could be enhanced by such as the **development of a community health forum**[3] as in Australia so there is an informed group of people (rather than representative groups centred on single health issue) who can ensure public interest is considered by RAs and others in the sector.

[2] In medicine it is considered public understanding would be enhanced by title protection of the term "medical practitioner", "registrar" and "vocationally registered medical practitioner". This would required the Medical Council, Ministry of Health and DHBs to work together to inform the meaning of these terms.

[3] Community Health Forum of Australia is the peak organisation providing leadership in representing the interests of Australian healthcare consumers working to achieve safe, good quality, timely healthcare for all Australians, supported by the best health information and systems the country can afford.

Lay representation

RAs also have lay persons on their Boards and Councils. It is CMC view that the lay representation on RAs is sufficient (where approximately a third of the members are lay members).

However RA governance could be enhanced by **all** RA board members being selected on the basis of skills and experience. This matter was to be addressed following the 2008 review but as yet, little has a happened. Work has taken place in the United Kingdom on these matters. Criteria from the UK review and other work in this area is set out in *Appendix 1* and could be used in New Zealand.

The purpose of lay person involvement is to represent the public interest and so the most effective lay persons have linkages to their communities.

Public involvement

The "public are already involved in HPCA Act regulation though lay people being on RA boards and their involvement in all committees set up under the HPCA Act which review conduct and practice. This lay involvement on RA boards gives a different perspective to the views of health professions. Competent lay involvement is welcomed by most professional groups regulated under the HPCA Act and this involvement does impact on RA decision making at all levels.

The processes used by the health professions regulated by the HPCA Act are a great deal more transparent than for health professionals not regulated by the HPCA Act.

3. Safety focus

Linkages with other legislation

The sector already does rely on the linkages between the HPCA Act and the Health and Disability Commissioner's Act 2000, the NZ Public Health and Disability Services Act, and the Health and Disabilities Services (Safety) Act 2001.

These linkages could be enhanced by a common set of definitions of matters for example definitions of phrases such as 'risk of harm' and 'serious harm' and common approaches to risk assessment.

Using other legislation /standards

The health regulatory sector has not used the New Zealand Standards in development of their work in areas such as standards for risk assessment, consent or cultural competence. This is different to other areas of occupational regulation – for example the Plumbers Drainlayers and Gasfitters Board (which operates in very similar ways and under very similar legislation to the RAs) actively use the NZ Standards in their area as a standard of acceptable practice.

Better linkages of RA work with New Zealand Standards potentially would give a better link between the different RAs work and that of the District Health Boards who are assessed against NZ Standards Health and Disability sector standards. It could also decrease the multitude of different standards and guidelines used across the sector.

Sole practice

In terms of regulation under the HPCA Act sole practitioners have to meet RA requirements. This is a benefit of the HPCA Act and of the individual focus of this type of occupational regulation.

Sole practice of itself is not essentially more risky than for example the risk from an isolated team member working in a large hospital. These risks have to be assessed at the individual level which is why the HPCA Act focus is on the individual.

The Medical Council and Colleges have already developed mechanisms such as peer review, practice reviews and for general practice use of the Cornerstone practice accreditation to mitigate such risks.

4. Cost effectiveness

4.1 Risk assessment

The RAs already operate on an assessment of risk. There is always a balance between decreasing risk and the cost of applying such process. For example risks could be decreased if all practitioners underwent an annual practice review but the cost and disruption to service would be out of proportion to the gains.

Increasingly, RAs are looking at effective methods to identify practitioners that may put the public at risk. This type of risk profiling needs to be based on clear evidence and applied with care.

Defining risk of harm

The working definition developed by the Medical Council has been accepted by the sector.

CMC would not advocate any more detailed definition of harm or serious harm as this may limit flexibility, future proofing and the ability of the RA to intervene.

4.2 Regulatory options

It is understood that one of the key drivers for review of the HPCA Act is that many more groups want to be regulated under the HPCA Act. This desire is not always linked to the risk that the health professional group poses to public safety but HPCA Act coverage is seen to give mana or acceptability to the group. Any increase of the number of groups covered by full statute as by the HPCA Act is potentially costly and unnecessary.

CMC accepts that regulation such as the HPCA Act should be based on the perceived risks for public safety. CMC has no concerns about other forms of regulation if appropriate such as employer regulation and an accreditation system for voluntary registration for groups that pose a lower risk to the public as is now happening in the United Kingdom but any change should be based on robust policy analysis.

CMC endorses the current criteria operated by HWNZ to assess which groups should be regulated by the HPCA Act and which pose a risk of harm (with the inclusion of the words bolded below)**.**

That is, groups that pose a risk of harm to the public includes those that performs:

- Invasive procedures (including but not limited to cutting under the skin or inserting objects into the body),
- Clinical interventions with the potential for physical or mental harm,

And where the group

- Make decisions or exercise judgements which can substantially impact on patient health or welfare, where the individuals work autonomously, i.e. unsupervised by other regulated health professional **and can set up individual practice.**

Some CMC members would include the words bolded above (i.e. **and can set up individual practice**) and consider that, if these criteria were strictly and robustly applied along with the other criteria set out in the Ministry of Health Guidelines Applying for Regulation under the Health Practitioners Competence Assurance Act 2003, some of the current professions would not be regulated by the HPCA Act and most new professions seeking coverage would not reach the bar. This would reduce the growth in the number of regulated group and thus the costs.

However it was also noted by one member that "diagnostic and therapeutic use of ionising radiation such as x-ray and gamma rays should also be included in the above criteria. This may be better tackled by reconsidering the "restrictive activities as set out in Section 9 of the HPCA Act.

Another CMC member supports the need to regulate scopes of practice that include activities that may do harm, ***and*** are performed by health professionals who may not work autonomously. They note that regulation should be based on a robust scope of practice and for some; this should include the requirement to work under supervision or delegation in order to protect the public while enabling safe, appropriate and flexible practice.

Any change to use other regulatory frameworks (other than the HPCA Act) needs careful policy analysis of the risks, costs and benefits.

One benefit of the HPCA Act is that all regulated health practitioners are regulated in a similar way. The HPCA Act was international ground breaking occupation legislation when introduced in 2003 because the same requirements were applied to all health professionals recognised by the HPCA Act thereby providing *a consistent accountability regime for all health professions* (Section 3(2) (a)).

One area noted as being useful regulation of all team members under the same frame work is the current situation of the anaesthesia team. For example, before the advent of the HPCA Act - only doctors were protected by the Quality Assurance Activities (QAA) provisions of the Medical Practitioners Act 1995 and this interfered with team review within morbidity and mortality committees as not all team members were protected. Since the advent of the HPCA Act, all regulated health practitioner members of a team have been covered by Sections 52-63.

Therefore different forms of regulation of different health team members may be counterproductive to improving team work.

4.3 Data collection

Most RAs do collect data at the time practitioners apply for their practicing certificates. It is accepted that this data is crucial for workforce planning. A change in the HPCA Act under Section 138 to enable the RAs to report non identified data to HWNZ would overcome most privacy concerns.

That said common definitions need to be applied across all RAs, for example what 'part time' is, how many hours are 'full time', whether practising means holding practising certificate or actually working. There also needs to be a common data set as for example, some RAs now collect information of practitioners leaving New Zealand - i.e. when the practitioner requests a certificate of good standing.

Extensive work to standardise the data collected was started by the Ministry of Health using the Health Practitioners Index but this work has not been forwarded. This matter should be taken up by the Health IT Board as it will also require linkages with providers and employers data to be effective for workforce planning and cover the large number of non regulated health worker groups.

4.4 Increasing standardisation across professional groups.

It is noted that the regulatory framework for standardisation across RAs already exists through Section 3(2) (a) where the principal, purpose of the Act is to be implemented by *providing, among other things,—for a consistent accountability regime for all health professions.*

Standardisation of codes and standards

- The new RAs (i.e. those created since the start of the HPCA Act) did use existing codes of ethical conduct, standards of clinical and cultural competence when developing their own standards, so some synergies already exist.
- This standardisation could be extended through cross RA work and working together to achieve some consistency is explicitly empowered by Section 118(j). (Use could be made of a NZ Standards approach which is used by some other occupational regulatory bodies to get cross sector consistency).

  However each group of health practitioners will have their own specific issues that need to be addressed in codes and standards. Some codes and standards link to international instruments and many have a common Trans-Tasman basis therefore one code or standard for all health professionals is not practical or even desirable.

Combined RA secretariats

Some synergies may be possible by combining some of the RA secretariats but this trend must not be at the cost of the basic purpose of the HPCA Act that is to ensure that health practitioners are competent and fit to practise their professions. This requires strong input by the practitioner groups themselves.

Changes in secretariat size should only be made where the benefits can be transparently demonstrated.

Statistic collection so workloads and efficiency can be assessed

The 2008/9 review noted that the work of the RAs may be better assessed if there were some common statistics collected across the RAs i.e. *That the Ministry of Health arrange for a set of indicators to be developed, in consultation with responsible authorities and other interested stakeholders, to measure the effectiveness of the Health Practitioners Competence Assurance Act 2003 and to measure the performance of responsible authorities*. Work in this area would be of benefit to all, as would the agreement across the RAs to collect a common set of statistics as currently they do not collect the same information in the same way. For example there is no common collection of matters such as the average time to deal with a complaint or the main causes of complaints. More work in this area could lead to cross-RA learning and development of best practice and benchmarking.

4.5 Size and number of RA Boards

There is extensive research on effective size of governance boards, the RA board should be no different and have 8-10 members appointed for their skills rather than groups they may represent. Boards also need to be clear on their role and be selected to bring the required governance skills - see *Appendix 1*.

It is noted that in the United Kingdom there are fewer regulatory Boards as several of the smaller professions are regulated by the Health Professionals Council. This structure may assist the smaller professions in New Zealand where six of the RAs regulate fewer that 1000 practitioners.

Changes in the number of RA boards should only be made where the benefits can be transparently demonstrated.

4.6 Improving employers' ability to manage costs

RAs should be mindful of the impact and cost their work has on the sector, that said they are required to implement the HPCA Act. They should work within the parameters of good regulation as developed by the United Kingdom Task force on *Better regulation* i.e. being proportionate in their actions, accountable and transparent[4].

It is noted that the DHBs/employers carry the cost of the practising certificates and recertification because of industrial agreements negotiated by the DHBs rather than any requirements of the HPCA Act. RAs are also required to consult on the fees they charge and standards they set.

RAs should consider costs impacts in term of their decisions as long as this does not increase risks to the public.

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[4] **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: Regulation should be focused on the problem, and minimize side effects. (Better Regulation Taskforce , 2007)

RA role creep

RAs should also be required to **only** take on the roles specifically empowered by the HPCA Act i.e. Section 118 or else there is role creep which can be costly.

4.7 Other issues

Mandatory reporting

CMC members have noted that the current HPCA Act does not require mandatory reporting of possible competence concerns. This type of reporting has been introduced though recent changes in health occupational regulation Australia. Given the complexity of the issue, we suggest that it could be time to have another discussion on this matter in New Zealand.

To forward this matter, extensive consultation is needed with the sector and with other groups such as the RAs and the Health Commissioner.

Appendix 1

The review of health regulation in the United Kingdom in 2007 faced concerns about the functioning of RA boards and consequently developed 12 key principles for an effective regulatory governance board and personal attributes and competencies for Board members including lay people.

Key principles for an effective Board

1. The board should determine the purpose and values of the RA and review these regularly.
2. It should be forward and outward looking, focussing on the future, assessing the environment, engaging with the outside world, and setting strategy.
3. It should determine the desired outputs and outcomes of the RA in support of its purpose and values.
4. For each of its desired outputs and outcomes, the board should decide the level of detail to which it wishes to set the organisational policy.
5. Any greater level of detail of policy formulation should be a matter for the determination of the chief executive/registrar and staff.
6. The means by which the outputs and outcomes of the organisation are achieved should be a matter for the chief executive/registrar and staff.
7. As general principle, the board should not distract itself with the operational matters.
8. The chief executive/registrar should be accountable to the board for the achievement of the RA's outputs and outcomes.
9. In assessing the extent to which the outputs and outcomes have been achieved, the board must have pre-determined performance criteria (KPIs) which are known to the chief executive/registrar and staff.
10. The board should engage with its stakeholders regularly and be confident that it understands its stakeholders' views and priorities.
11. The membership of the board should be capable and skilled to represent the interests of the stakeholders; this should not be done in a tokenistic way.
12. The board must govern itself well, with clear role descriptions for itself, its chair, and its members, with agreed methods of working and self-discipline to ensure that time is used efficiently and to regularly monitor its performance.

Personal attributes for RA board members

- Honesty and accountability: Truthfulness and trustworthiness, without compromise of moral principle, and willingness to act on and remain accountable for Board decisions. Accepts own accountability while holding others to account for their performance.
- Commitment: The energy, motivation, time and contribution necessary to properly meet the Board's requirements and discharge its responsibilities.
- Independence: The strength of character and independence to probe and achieve full understanding of the issues.
- Objectivity: The ability to be objective and free from influence any relationship that could materially interfere with the exercise of objective judgement.
- Leadership: The ability to take leadership roles and to encourage members of the board and management to develop leadership roles and skills.
- Motivation: Motivation and an ability to learn.
- Informed judgement: The ability and intelligence to make fair and reasonable decisions and recommendations in a timely manner based on reasonable assumptions and factual information.
- Integrity: High ethical standards and integrity in all personal and professional dealings.
- Common sense: Sound practical sense in everyday matters.
- Communication: The ability to articulate opinions, rationales and points clearly, logically and concisely, and participate in RA discussions with courtesy and respect. Respects the views of others and is not resistant to change.
- Adaptability: The ability to adopt a flexible approach in team interaction and to alter stances when appropriate.
- Listening: The ability to listen impartially and not be selective, and recall and take into account key points.
- Teamwork: The ability to work harmoniously within a group, to recognise, respect and value the contributions of other members in a diplomatic manner, and to support and accept majority RA board decisions.

Knowledge, qualifications and experience for RA board members

- Experience: Experience and knowledge about the health sector and the regulatory environment.
- Board responsibilities: An understanding of the New Zealand regulatory, legal, fiduciary and ethical requirements affecting members and stakeholders.
- Management practices: Familiarity with up to date management techniques and related ethics.
- Environment: Awareness of health sector environment and impact of professional both nationally and internationally.
- Organisational structure: An understanding of the roles, processes and relationships between the RA and its stakeholders.
- Performance appraisal: An understanding of the key performance indicators of the RA's Chair and members and the RA's CEO and /or Registrar.
- Legal and financial: An understanding of legal and financial reporting standards and of accounting principles and practice and information technology: An understanding of the need for and the systems used by RA's for collecting data on professionals and the ways this can be stored and retrieved and the privacy issues around transferring information.

General Competencies for RA board members

Governance

- Governance: Understanding of governance practices and the ability to distinguish between issues and actions of governance as distinct from management, and not directly be involved in management matters.
- Managing performance: The ability to interpret information and data and apply it to managing and monitoring the performance of the RA and the ability to motivate the performance of the regulator to improve.
- Conflicts of interest: The acumen to identify and declare conflicts of interest on any issue coming before the board.
- Collective responsibility: The understanding of board operation, joint decision making and collective responsibility.

Regulatory and public service

- Public interest/involvement focus: Understands the six Nolan principles of public life[5]
- Public protection: Commitment to protecting patients and to securing public/patient involvement.
- Regulation: An understanding of the health regulation and the context in which it performs the full range of its statutory duties and responsibilities.

[5] The Nolan Committee on Standards in Public Life and developed the "seven principles" which are; Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership

Strategic competencies

- Strategic issues: Including strategic thinking, business knowledge and sound judgement.
- Intra-Organisational awareness: The ability to see the overall strengths and weaknesses of the RA the manner in which it operates and the impact of decisions on the RA.
- Extra-Organisational awareness: An understanding of the position of the RA in relation to the wider health sector, the profession, the media and the public.
- Compatibility and prioritisation: The ability to ensure that strategies, budgets and business plans are compatible with the RAs principal purpose and functions and, in monitoring performance, to identify and focus on those issues that are of significance to it.
- Change awareness: The ability to be alert and responsive to the need for change, to encourage new initiatives and to implement new policies, structures and practices. Able to think and plan based on the long view, balancing needs and constraints, risks and opportunities.

Analytical competencies

- Financial literacy: The ability to interpret financial statements and statistical information such as balance sheets, profit and loss accounts, cash flow statements and key performance indicators and to recognise their significance, quality and timeliness.
- Critical faculty: Independent thought and the ability to probe the facts, challenge assumptions, identify the advantages or drawbacks of proposals, provide counter-arguments and ensure discussions are penetrating and constructive.
- Information oriented: The confidence to ask for and receive information on matters of significance and relevance, enabling informed judgements/assessments to be made.