Te Kaunihera o Ngā Kāreti Rata o Aotearoa
COUNCIL OF MEDICAL COLLEGES
NEW ZEALAND

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Tēnā koe Steve

Re: Consultation: Proposal to regulate the Physician Associate profession

Thank you for the opportunity to provide feedback on the above proposal. Thank you also for attending the CMC meeting on 17 August to discuss the proposal with us in person.

The Council of Medical Colleges is the collective voice for seventeen medical Colleges in Aotearoa New Zealand, and through its members aims to improve, protect and promote public health via a well-trained medical workforce providing high-quality medical care. Our member Colleges provide support to over 9000 specialist medical practitioners working in a range of disciplines in the Aotearoa New Zealand health system. All Colleges have an interest in decisions that impact the wellbeing of patients, whānau and communities throughout Aotearoa New Zealand - making this proposal of significant interest.

The Council of Medical Colleges advocates for a robust, well-trained, culturally safe health workforce that meets the needs of patients and whānau in Aotearoa New Zealand. Our quality healthcare depends on an ongoing and adequate supply of trained health practitioners to meet the changing needs and growth of our population.

CMC is deeply concerned at the limited consultation process, meaning important considerations may be missed simply because those likely to be most impacted could not share their individual perspectives except through CMC as a peak body. We consider that, in relation to new initiatives that will impact on patient care, all stakeholders should be provided with the opportunity and sufficient time to respond appropriately and thoughtfully.

CMC is very uncomfortable that regulation may be formed and potentially passed into legislation without full and broad-based consultation with all impacted professional groups.

On the respective merits of the proposal to regulate Physician Associates, Colleges have opposing views, and this submission attempts to summarise their respective positions in response to the questions you provided. In general, Colleges with broader scopes of practice are opposed to regulation, those with more defined scopes of practice can see some value in regulating.

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CMC consider maintaining the emphasis on equity, quality and 'growing our own', and supporting our medical workforce to remain in Aotearoa New Zealand, is a key indicator of equity and safety, and suggest that this approach underpins all decisions about health workforce. Any government investment in the introduction of a new workforce that needs regulation will be considerable, and a diversion of finite health resources for unknown benefit is likely to be met with extreme opposition from some Colleges.

Before responding to the questions posed by the consultation document, we would like to raise two important concerns from the outset. First, the apparent lack of coordinated, strategic health workforce planning which we may expect to result in a proposal to regulate a new workforce to fulfil a clearly identified scope and niche which cannot be met by the established workforce. Secondly, all Colleges hold concerns about the lack of Hauora Māori knowledge, cultural competence, and cultural safety skills in an entirely overseas trained workforce, which poses a fundamental risk to patients. Finally, we have serious concerns with the structure of this consultation and poor data it will collect as a result.

Health Workforce Strategy Questions

CMC is concerned about the drivers for regulation after so many years without regulation of Physician Associates, and without clear evidence for how regulation will see direct improvement in patient outcomes.

The Physician Associate workforce within New Zealand currently sits around 12, and practices who have worked with Physician Associates report variable experience. Some state that they find Physician Associates to be experienced, well trained, and technically proficient, others have found them to be inexperienced and out of their depth. The risks associated with the potential introduction of a new workforce group under a new scope of practice, with variable or absent evidence of benefit in patient outcome, is very concerning.

CMC notes that there appears to be limited to no strategic analysis as to the role and function of Physician Associates in the broader Aotearoa health workforce, and the impact on the supervision and training of other health practitioners. It is not clear what role Physician Associates would provide, that isn't already covered by an existing, already regulated health workforce, with locally available training programmes. Before regulation occurs, it should be considered whether the Physician Associate profession offers something particularly unique to the Aotearoa health workforce, or whether workforce shortages could be filled by adequately resourcing the training of existing, established professional groups such as nurse prescribers and nurse practitioners.

There are already workforce shortages in the health system, therefore the number of incoming Physician Associates would need to be carefully matched to the workforce providing supervision and oversight. The proposal to regulate Physician Associates seems out of step from the nationally coordinated workforce planning approach adopted by Te Whatu Ora in its Health Workforce Plan 2023/2024, which includes a focus on:

- growing pathways for Māori and Pacific Peoples in health;
- driving local-led innovation in training; and
- bolstering priority workforce groups including increasing training numbers in foundational professions such as medicine and nursing.

Importing an internationally trained workforce that doesn't have a training programme in Aotearoa runs counter to each of these action areas.

The proposal to regulate Physician Associates is ill-timed as Manatū Hauora begins work with other agencies, such as Te Whatu Ora and Te Aka Whai Ora, to use the Health Workforce Strategic Framework to lead the development of

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policies aimed at addressing the issues faced by the health workforce. This policy development focuses on three key areas:

- reviewing how skills and capabilities are recognised and developed across the health workforce
- exploring how investment can value and incentivise the skills and capabilities needed to improve health outcomes
- reviewing processes in place that assure quality and safety, balanced with the flexibility needed to improve health outcomes.

It is unclear how this proposal to regulate supports any of these initiatives as the Physician Associate role appears to duplicate the functions of the Nurse Practitioners. Nurse Practitioners are a local workforce who reflect our population, are well versed in the cultural nuances and health system of Aotearoa New Zealand, trained in Aotearoa New Zealand, and therefore their training can be tailored to meet our workforce needs. No case has yet been made for why regulating an international workforce would be more efficient or appropriate than supporting increased numbers of our Nursing and Allied Health colleagues – particularly for Māori and Pacific nurses to be supported into new roles.

CMC would like to see greater support and funding for Nurse Practitioners as a higher priority - before the Physician Associate workforce is embedded in the Aotearoa New Zealand.

Cultural Safety Concerns

Colleges recognise that requiring overseas-trained Physician Associates to undertake targeted education in cultural safety, equity, and acquiring knowledge of our unique rural or geographical challenges is not a quick solution to enabling culturally safe practice by any health worker trained outside of Aotearoa New Zealand.

We understand that James Cook University Queensland is the nearest facility offering training for Physician Associates. Equipping, training, and supporting Physician Associates to work within Aotearoa New Zealand will be challenging on several levels. The cultural aspects of life in Aotearoa New Zealand are unique, and it is our understanding that overseas-trained health professionals not only struggle with cultural differences but with systems differences e.g., ACC, Pharmac etc. Currently the health system in Aotearoa New Zealand is investing greatly in developing a te Tiriti-centred approach to health care. Many health professionals are working hard to ensure they are culturally safe, therefore there are limited resources to deliver these supports and services to those currently in the health system. Developing the cultural capabilities of the Physician Associate workforce will take valuable resources away from the health professionals currently working in the system.

Colleges' chief concern relates to how the regulatory authority will ensure that these health professionals will be upskilled in meeting Te Tiriti o Waitangi obligations and deliver a service that is culturally appropriate. The Ministry of Health has released their vison of the future with Pae Ora - Healthy Futures, which has a strong emphasis on providing care that is led by Māori/Pacific, for Māori/Pacific. Physician Associates will be working in areas of high need where there are likely to be a high percentage of Māori and Pacific patients – and it is not clear how this professional group will be woven into this strategy and what impact they will have on reducing health inequalities.

Cultural safety training for Physician Associates entering Aotearoa is essential, along with Te Tiriti training to ensure they have the understanding to practice safely in this environment and reduce health inequities. Some Colleges argue that the Physician Associates regulatory authority would need to partner with relevant Māori and Pacific leaders and organisations regarding developing a programme to ensure Physician Associates are culturally safe. It would be appropriate to involve Māori and Pacific patients in designing this programme, whilst avoiding cultural loading for these patients, doctors and other collaborators.

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Colleges strongly recommend that if regulation were to be perused, the regulator must be responsible for standards and a programme for hauora Māori understanding, cultural competence and cultural safety, based on alignment with Te Tiriti o Waitangi and Pae Ora, in the context of the Te Tiriti o Waitangi, and the Whakamaua Māori Health Action Plan 2020-2025. Every Physician Associate would need significant training in cultural safety, orientation to Te Tiriti o Waitangi and health services within Aotearoa, New Zealand. Currently doctors coming into the country have requirements of orientation that vary between 6 months and 2 years, Colleges expect would be the same for Physician Assocates.

Consultation Structure Challenges

One of the challenges of this particular consultation structure is that it prevents individual Colleges contributing their own views, and there is not always a shared view across the Council of Medical Colleges. In this case, Colleges hold opposing views.

When considering whether to recommend regulation of the Physician Associate profession, Colleges ask themselves a range of questions. One of the questions, as also posed by the Ministry, is whether or not the proverbial 'horse has bolted' indicating if the Physician Associate workforce has established here in Aotearoa New Zealand.

For those who consider the 'horse has bolted', these Colleges recognise the potential risk Physician Associates could pose to the safety of New Zealanders. They highlight that the relationship between the supervising specialist and the Physician Associate is essential, and an adequate degree of supervision and clinical oversight is required. Will regulation improve this supervision and oversight (which is already a requirement) or lessen it? These Colleges add that caution needs to be employed around definition of scope and training to ensure that Physician Associates have adequate training for the role they perform.

Those who consider the 'horse has not yet bolted' refute the inference as justification for regulation.
They claim that, despite the indication from the Physician Associate Society, large numbers of Physician Associates may intend to join the Aotearoa New Zealand workforce, few will eventuate in reality. They are concerned with the feasibility of regulating an international role that is currently inconsistently defined and variable, and consider it will be fraught with difficulty. Opening the floodgates to a new healthcare group should not undermine or detract from other professional healthcare and medical teams. These Colleges consider there is considerable risk of unintended consequences to the introduction of an untested, international workforce, even if regulated. They caution that Physician Associates are being perceived as an affordable alternative rather than investing in training, retaining and valuing doctors, nurses and others within their current teams. A nurse practitioner, nurse or pharmacist with prescribing rights, working within many community based setting would provide equivalent service to a physician associate.

The Ministry of Health's consultation process appears to lack transparency and inclusivity. There is uncertainty regarding which organisations or individuals were invited to participate in the consultation and how these participants were chosen. Furthermore, the document specifies that it should not be widely distributed and does not accept unsolicited submissions, raising questions about the purpose of such a limited consultation approach.

This approach to consultation carries a significant risk of excluding organizations with legitimate interests and may introduce bias into the process. According to Section 116 of the HPCA Act 2013, consultation should involve "any organization that, in the Minister's judgment, has an interest in the recommendation". In our perspective, interested organizations should encompass all those involved in training, supporting, and regulating nursing, allied health, and medical professions. It remains unclear whether these groups were indeed included in the consultation.

Additionally, the presence of leading questions raises concerns that the outcome may already be predetermined. These leading questions can steer responses in a certain direction, potentially biasing the results and undermining the credibility of the consultation's findings. It is imperative that any consultation process, especially one involving such

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significant regulatory decisions, be conducted with utmost transparency, neutrality, and openness to ensure fair and unbiased outcomes.

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Questions:

1. Do you agree that the Physician Associate profession provides a health service as defined under the HPCA Act, and poses a risk of harm to the health and safety of the public?

Yes, the Council of Medical Colleges agrees that the Physician Associate profession provides a health service. Colleges differ in their evaluation of the risk of harm to the health and safety of the public. Some consider that the Physician Associate profession potentially poses a risk of harm. Other Colleges consider the evidence for Physician Associate current practice and safety insufficient and unavailable in Aotearoa New Zealand - as the role is variable overseas it is difficult to compare activities in different countries to our context regarding the safety of their practise.

2. Do you agree with the Ministry's assessment of the nature and severity of the risk of harm posed by the Physician Associate profession? If not, please provide comment.

There is disunity amongst Colleges about whether the Ministry's assessment of the risk posed by the Physician Associate profession is appropriate. Some Colleges consider the Ministry's assessment is based on insufficient evidence. While feasibility of three Physician Associate was tested in two rural practices and one urban practice, there is no evidence available about the risk to public health and safety of the unregulated workforce.

Other Colleges support Physician Associates in principle, and consider they can be useful adjuncts to the medical profession when regulated appropriately to safeguard public health and safety and to ensure a consistently high-level standard of care that is appropriate for the Aotearoa setting.

Many allied health roles - health coach, health improvement practitioner, community support worker, kaiawhina, primary care practice assistant – operate safely without regulation. Regulating the Physician Associate Profession in Aotearoa New Zealand does not guarantee improved patient safety and may, in fact, lead to reduced supervision and oversight, following the pattern seen in other professions. This concern is particularly pertinent when dealing with healthcare professionals trained in international and unknown environments, with skills that may not be a good fit for the need they are employed to fill within the New Zealand healthcare system.

3. Do you consider that, under the Ministry's guidelines, it is in the public interest to regulate the Physician Associate profession under the HPCA Act?

The Physician Associate profession is a variable unregulated workforce, and Colleges do not agree on whether it is a priority for Physician Associates to be regulated. Colleges do, however, agree that people receiving medical care from a Physician Associate should be covered by the Health Practitioners Competence Assurance (HPCA) Act (2003) as if they were treated by any other health provider.

From a regulatory perspective, some Colleges argue that existing controls are clearly inadequate as there are no official regulation of Physician Associates. The New Zealand Physician Associate Society has a voluntary register of Physician Associates - self-regulation and employee regulation are likely insufficient to ensure consistency and comparability of controls. As Physician Associates are not regulated it is unclear how a patient who experiences adverse outcomes is covered by ACC Treatment Injury Provisions. Section 12 of the HPCA Act prescribes the qualifications of the profession, therefore it would be good practice to establish a Regulatory Authority whose role would be to define the appropriate qualifications of a Physician Associate and assess incoming PAs,.

From a patients perspective, adding another new role to the health workforce could cause confusion. Some Colleges argue that Aotearoa New Zealand has developed several alternate health worker roles over the last few years - health coach, health improvement practitioner, community support worker, kaiawhina, primary care practice assistant. These roles are currently being bedded into services – despite not being regulated. There has been no evaluation of these roles and adding another undefined role to this workforce has the potential to undermine some of these existing roles.

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Patient confusion about the role of current allied health practitioners exists already in Aotearoa New Zealand. Adding in another role that is not a domestic qualification will add to patient uncertainty, though conversely, some Colleges suggest regulation could provide clarity as to how Physician Associates sit relative to the roles of current allied health practitioners already in Aotearoa New Zealand.

The Physician Associate workforce is an unknown workforce with no current Scope of Practice to guide integration, and as such, some Colleges do not consider that existing controls would be sufficient to ensure equity and public health and safety. It is not clear how the qualifications of the Physician Associates currently working in Aotearoa New Zealand (NZ) are assessed, or what criteria would be used to assess the qualifications of an emergent workforce. Overseas trained health professionals (medical practitioners, nurses and allied health professionals) entering Aotearoa New Zealand are rigorously assessed before they can practice in Aotearoa New Zealand against Aotearoa New Zealand standards. With Physician Associates, there is no New Zealand based training to compare against. It is also not clear how the overseas training programmes are accredited, and it may be possible that there are inconsistent standards across the training programs.

Colleges argue that it is not the regulation of an allied health profession that ensures public health and safety – it is the supervision by Specialists providing time and experience to ensure patient safety. Physician Associates working in a large team-based hospital settings may have better access to supervision and support whether regulated or not. Access to support, resources and supervision in primary and community-based settings is limited and even more so in smaller and potentially isolated general practices. It is important that Physician Associates working in primary care do not have full autonomy over clinical care of patients.

General Practice specifically raise the concern, with current workloads of GPEP training, medical student training, new prescriber training, and other supervision, of limited capacity within the existing workforce to integrate a mass introduction of a new international workforce into general practices. The focus of specialist GPs in supervision and training is currently on medical students, RMOs, vocational trainees and overseas GP specialists entering New Zealand as well as nursing, nurse practitioners and other allied health professionals. Adding another professional group to this knowledge transfer of community-based medicine is untenable and would create additional patient risk. There is no capacity or funding for them to provide supervision services and it is likely that it would impact on time spent with patients.

4. Do you consider that the existing mechanisms regulating the Physician Associate profession are effectively and adequately addressing the risks of harm of Physician Associate's practice?

If Physician Associates are recognised as a profession under the HPCCA this would be a positive outcome – however, supervising, mentoring and supporting Physician Associates would need to be part of the medical practitioner's clinical practice and this will impact on their workload. In community based or general practice settings, this is managed and remunerated differently as it is in hospital-based settings as it has a direct impact on patient access to care.

Scopes of practice must be clearly defined if the Physician Associate profession is to be regulated. Under s.11 of the HPCAA regulated professions must have specific scopes of practice and this may help to clarify the role of Physician Associates by outlining the tasks commonly performed and the illnesses or conditions to be diagnosed, treated, or managed by Physician Associate.

S.8 of the HPCAA states that health professions cannot practice outside their scope. Some Colleges argue that regulating Physician Associates would further protect the public, and ensure there is not a significant over-lap with other health professionals/ health providers working within the team. Appropriate recognition of Physician Associates

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and their supervisors could facilitate this relationship and make responsibilities of Physician Associates and doctors clear.

5. Could the existing regulatory mechanisms regulating the Physician Associate profession be strengthened without regulating the Physician Associate profession under the HPCA Act?

Workplace settings, supervision, and oversight play pivotal roles in ensuring the effectiveness and safety of healthcare delivery. The current mechanisms appear to lay great risk and responsibility at the feet of those doctors who supervise Physician Associates, and regulation will not release them of this.

Colleges who are in favour of regulation argue that employers would need to bolster their mechanisms for ensuring that individuals are fulfilling their job responsibilities adequately. They suggest integration with an existing regulatory authority could help guide Physician Associates towards an established curriculum and best practices as determined by their Regulatory Authority. They can - and should - still reference local or regional resources to ensure their capabilities as culturally safe health practitioners.

Colleges who are not in favour of regulation consider enhancements to the following existing strategies would be a reasonable response to safeguard public health and safety:

- Ongoing supervision of Physician Associates by medical professionals. Supplementary support systems and funding will need to be provided to doctors who supervise Physician Associates.
- Using the enforcement measures outlined in section 9 of the Health Practitioners Competence Assurance Act in cases where an individual Physician Associate undertakes tasks beyond their scope or otherwise restricted to specific healthcare practitioners.
- Holding Physician Associates accountable for their actions under the provisions of the Health and Disability Commissioner's Code of Health and Disability Services Consumers' Rights.

Colleges are concerned that Physician Associates may end up in rural or remote settings without adequate support, where the existing medical workforce and infrastructure is already stretched. This is more likely to occur if regulated Physician Associates claim increased autonomy, and has the potential to cause significant harm to patients within more vulnerable communities.

6. Are there other regulatory mechanisms, short of regulation under the HPCA Act, that could be established to minimise the risks of harm of the Physician Associate profession? Please provide comment about your answer.

Regulated or not, every Physician Associate entering the country requires supervision – which is a substantial burden for the current workforce to carry – and an induction on cultural safety and understanding New Zealand health system. Physician Associates will be working in rural and remote areas where it is difficult to access health care and where there is a high volume of complex presentations. It is critical that Physician Associates are appropriately supervised and supported in this challenging environment. Supervising Physician Associates may require a distinct set of supervision skills compared to those typically provided for the array of trainees and allied health professionals that Doctors mentor and oversee.

As Physician Associate training is variable across jurisdictions, there would be difficulty accepting every Physician Associate as they will not be equivalent to each other depending on where they come from, and what training they have received, making their relevance and benefit to New Zealand healthcare questionable. It is unclear if Physician Associates undertake any practice- based training (work placements) during their orientation to Aotearoa New Zealand. Practice-based training would require significant input from other health professionals. If regulated it should be the role of the Regulatory Authority to organize the work placements and then assess the PA, then appropriate orientation and induction should be provided by the employing agency. Participation in a Continuing Professional

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Development programme should be a mandatory requirement to maintain an Annual Practicing Certificate and comply with the Regulator requirements.

Supervision will mainly be provided by a medical practitioner, but other health professionals such as public health nurses and midwives would also need to be involved in providing support, guidance, and direction. In order for Physician Associates to work effectively and safely they would need to be fully orientated to our health system. Supervision would need to be structured and intense during the period of orientation. Given the small numbers of Physician Associates in the country it is unlikely that those already in New Zealand can provide any reasonable support to incoming Physician Associates, therefore other health professionals would need to be available to carry out these tasks.

7. Do you agree that regulation under the HPCA Act is possible for the Physician Associate profession?

Across CMC, Colleges are concerned at the inequity created through the use of an exclusively overseas trained workforce in Aotearoa New Zealand. Colleges have differing views on whether it is possible to regulate the Physician Associate profession under the HPCA Act.

Having Physician Associates trained overseas means that local practitioners may have limited experience and exposure to Physician Associates competencies. This can lead to scepticism or scope creep where parameters are relatively new to the supervising doctor. Wherever a physician associate is proposed some formal orientation and support system should be established to ensure supervising clinicians and current health workforce have a clear understanding of what Physician Associates are empowered to do. As such, we suggest greater clarity is needed about Physician Associate training, what they offer, and how the role relates to other health professionals their teams.

Some Colleges consider that it would be possible – and in fact beneficial as regulation under the HPCAA seems appropriate and consistent with other similar health professions who pose a risk to the community. While Physician Associates can provide a useful support to the medical profession, we need to ensure a consistent level of skill and competency across Physician Associates,. They need to be equipped to work in the Aotearoa setting, understanding our health system, and how to provide care in a culturally-safe way to patients. The supervisory relationship between Physician Associates and doctors should be formalised, with clear responsibilities and obligations.
The brief description of the Physician Associates role includes diagnosing, treating presentations, ordering tests, and undertaking simple medical procedures (such as suturing and excisions) that carry some risk of potential adverse outcome. It is noted on page 7 of the Ministry's Consultation document tha*t "Physician Associates work is (at times) physically invasive and carries serious potential for patient harm (including death) if not performed competently."*
The rationale for developing the Physician Associate workforce appears to be driven by increasing people's access to care but this desire needs to be balanced carefully with ensuring quality of care is not diminished. Part 3 of the HPCAA focuses on practitioner competence and fitness to practice. These principles need to be applied to the Physician Associate workforce, where it would be possible to track adverse events or risk of harm, review practitioner competence and reassure the public that Physician Associates are safe and competent to practice. A key tenet of Te Whatu Ora's Workplan 2023-24 is '*New Zealanders fundamental entitlement to quality care*" and we contend that through regulation a high-quality Physician Associate workforce can be established and developed.

Other Colleges consider there to be too many unknown factors surrounding Physician Associates and the role of the regulator that it is not possible to determine if it is possible to regulate Physician Associates. If the scope of practice of a physician associate across the globe is different in different countries, then we will not be getting a uniform worker.

This is due to a range of factors, namely that Physician Associates are not a uniformly trained health professional group with a defined scope of practice. Adding a workforce that has similar role to others within Aotearoa New Zealand undermines the value of those current roles that are taken up by New Zealanders in their home country. It

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would serve to confuse patients about what each scope of practice can do. They argue there is little need to regulate Physician Associates as there are existing avenues for health professionals within Aotearoa New Zealand to work - within the variety of scopes of practice that have been seen in the Physician Associate workforce - without adding another profession to confuse patients and add cost to the country.

Regulation and autonomy of an individual working within the general practice does not change the liability carried by the owners and directors of a service. This is not just about business ownership it is about clinical liability (quote the vicarious liability case). Regulation will not change this liability.
Regulation will not change the liability that sits with owners and medical professionals in practice in the community, nor does it come with supervisory resource, and defers doctors from their existing supervisory roles and from patient care.

8. Do you agree that regulation under the HPCA Act is practical for the Physician Associate profession?

Similarly, CMC does not have a consensus if Colleges consider that regulation under the HPCA Act is practical for the Physician Associate profession.

The first question that Colleges ask, in determining practicality, is 'is there an existing appropriate regulatory authority, or will we need an alternative regulatory authority?' The Regulatory Authority would need to have the ability to develop an appropriate recertification programme, specify tailored for Physician Associates. This programme could include resources on cultural safety and Aotearoa New Zealand health system - maybe a programme similar to Bpac's Inpractice. The Regulatory Authority would fully understand their practice when managing complaints/ competence reviews.

Some Colleges suppose that Physician Associates may not wish to be regulated by the Medical Council of New Zealand or the Nursing Council of New Zealand as they see themselves as a separate professional group from medical practitioners and nurses. Some consider the Medical Council the most appropriate regulator in the first instance, but once the number of Physician Associates gains critical mass they should then create their own regulatory group.

Some Colleges support an alternative regulatory authority for Physician Associates, so that the specific professional needs of Physician Associates avoid getting lost amongst those of medical practitioners. Others recognising that the costs of setting up a specific Regulatory Authority is prohibitive so needs to sit under an existing RA.
They argue that regulation under an existing authority has several benefits, namely reduced administrative burdens for integration, visibility of common workforce/sector issues and better compliance with legislative frameworks, unified platform for advocacy and transformational change programs, and scalability.

Regulatory authorities typically cannot cross-subsidize between professions, which means that the setup costs for regulation would need to be covered by the practitioners themselves. Given the relatively small number of Physician Associates currently in the country, the financial burden of establishing and maintaining a regulatory framework solely for this profession would be prohibitively high. This financial constraint raises questions about the feasibility and sustainability of such a regulatory endeavour.

Some Colleges vehemently oppose the Medical Council of New Zealand becoming the Regulatory Authority for the Physician Associate profession. They argue there could be a conflict of interest with MCNZ regulating Physician Associates as medical practitioners will be the main group of professionals providing oversight/ supervision/ mentoring to Physician Associates. If things go wrong, it would be wiser if the two professional groups have their own regulators to review the situation.

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It is critical that the views of the Medical Council of New Zealand and the New Zealand Nursing Council are sought. Neither Regulatory Authority may wish to become the regulator of Physician Associates given they would need to develop separate services, recertification programmes and committees to meet the regulatory requirements for Physician Associates.

9. Do you have anything to add to the consultation document's list of benefits and negative impacts of regulating the Physician Associate profession under the HPCA Act? Please provide comment about your answer.

An increasing reliance on exclusively overseas trained professionals to plug New Zealand's health workforce gaps is not a sustainable solution given the increasing global health workforce shortage. It is also not an equitable solution either, and there is widespread concern about the increase in exclusively overseas trained professionals with limited cultural safety knowledge and skills particularly in an Aotearoa context. Similarly, to regulate Physician Associates is to create a career pathway that New Zealanders are wholly unable to participate in, as training is unavailable within Aotearoa.

If one of the primary goals in healthcare workforce development is to achieve proportional representation of Māori and other ethnicities present in the community that are currently underrepresented within the health sector, the proposal to regulate an entirely international workforce appears to run counter to this. Fostering diversity and ensuring that healthcare professionals are culturally safe and representative of the communities they serve is essential for improving health outcomes. The introduction of an international workforce, while possibly addressing immediate worker shortages, may inadvertently undermine the broader objective of achieving equitable healthcare for all, including Māori populations.

The Ministry's assertion that Physician Associates are currently "constrained by existing supervision demands" and unable to fully utilise their skill sets is a significant concern. While it is acknowledged that supervision requirements exist to ensure patient safety and maintain the quality of healthcare services, it remains unclear which specific aspects of supervision would be relaxed if the Physician Associate profession were to be regulated. This lack of clarity raises alarm, as a loosening of supervision requirements, without a clear and comprehensive plan, could potentially jeopardise public health and safety. The concern stems from balancing practitioner autonomy while also safeguarding against any risks to patients – and medico-legal risk that remains with clinical supervisors - that may arise from reduced oversight.

10. Do you consider that the benefits to the public in regulating the Physician Associate profession outweigh the negative impact of regulation? Please provide comment about your answer.

The majority of Colleges do not believe that the advantages to the public outweigh the adverse effects of regulation, and it is too early to pursue regulation before there is greater clarity about the scope of practice, qualifications, and accreditation standards for Physician Associates. This should include an assessment of whether existing professions could address the identified needs effectively. Integrating a new solely internationally trained workforce into a health system in crisis will be a challenge in a financially constrained system and should not divert attention and finite resources from local initiatives that reflect and suit our population.

According to section 116 (b) of the HPCA Act 2003, consensus among healthcare service providers is required regarding the qualifications, standards, and competencies for scopes of practice. However, there appears to be no existing agreement on the scope of practice for Physician Associates between Colleges – let alone between various stakeholders, including the New Zealand Physician Associate Society, medical colleges, the Medical Council of New Zealand, the New Zealand Nurses Organisation, and the Nursing Council of New Zealand. Additionally, there is currently no training program in New Zealand for Physician Associates, although efforts are underway to develop accreditation and certification standards in collaboration with Australia.

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CMC recommends the Ministry of Health do not proceed with regulation but further evaluate the potential role of Physician Associates in the Aotearoa health workforce from a strategic perspective, taking into consideration Te Whatu Ora's Health Workforce Plan for 2023/24. To meet the requirements of section 116 (b) of the HPCA Act 2003, it is recommended that the scope, qualifications, and standards for Physician Associates be developed and subject to much broader consultation before considering regulation.

Thank you once again for the opportunity to comment. For any questions or further discussion on this submission, please contact Esther Munro (Executive Director) in the first instance at esther.munro@cmc.org.nz.

Nāku noa, nā

Dr Samantha Murton

Chair, Council of Meidcal Colleges