NEW ZEALAND
CHIROPRACTIC BOARD
TE POARI KAIKOROHITI O AOTEAROA

Submission: Putting Patients First – Modernising Health Workforce Regulation

Submitted on behalf of Te Poari Kaikorohiti o Aotearoa | the Chiropractic Board

Introduction

1. Te Poari Kaikorohiti o Aotearoa | The Chiropractic Board (the Board) welcomes the opportunity to comment on: *Putting Patients First: Modernising Health Workforce Regulation*. As a Responsible Authority (RA) under the Health Practitioners Competence Assurance Act 2003 (HPCA Act), we support reform that strengthens public safety, enhances cultural competence, and promotes equitable access to health services.
2. The HPCA Act provides a sound and adaptable regulatory foundation. We support refinements to strengthen the existing model, but do not support wholesale changes or centralisation that risks diluting public protection and profession-specific standards.
3. We acknowledge the consultation's ambition, though note the response timeframe, coinciding with public holidays, limits opportunities for more comprehensive sector engagement. As the proposals are refined, we encourage ongoing dialogue with all RAs. Should more extensive legislative reform be pursued, adequate time and transparency is essential for meaningful collaboration.
4. We question whether the consultation process meets the legal standard for genuine consultation. The structure and language of the consultation document suggest that amalgamation is a foregone conclusion, with limited scope for considering alternative models. In *Wellington International Airport Ltd v Air New Zealand*[1], the Court of Appeal emphasised that lawful consultation must take place at a formative stage, provide accurate and sufficient information, and demonstrate a genuine willingness to consider alternative viewpoints.
5. In contrast, this consultation presents a narrow set of options, lacks clear articulation of risk, and appears to seek input primarily on implementation rather than underlying policy direction. These shortcomings raise serious concerns about whether the process complies with public law obligations.
6. In addition to these legal concerns, we note the consultation process appears to fall short of the core values outlined by the International Association for Public Participation (IAP2). These values were endorsed by the Government, including the Department of the Prime Minister and Cabinet (DPMC)[2] and the Public Service Commissioner, as a principled approach to meaningful public engagement.
7. This process does not appear to meet the IAP2 values of "seeking input on issues that affect people," "providing participants with the information they need to participate in a meaningful way," or "communicating how input will influence decisions." We encourage the Ministry to adopt these values more fully in future phases of reform.

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[1] *Wellington International Airport Ltd v Air New Zealand* [1993] 1 NZLR 671 (CA)

[2] https://www.dpmc.govt.nz/our-programmes/policy-project/policy-methods-toolbox/community-engagement

Patient-Centered Regulation

8. We support regulation that centres patients and the public. Current frameworks already promote this through transparent consultation, lay representation on Boards, and policies that prioritise public safety.
9. To further this, we would welcome the establishment of a national, resourced consumer rōpū to offer inclusive, cross-sector input. This should reflect Aotearoa's diversity and operate in an advisory capacity to complement, not replace, RA-led consultation.
10. We support increased lay representation on Boards, provided profession-specific expertise remains well represented. This balance ensures both community voice and professional perspective in decision-making.
11. Cultural safety is a legislated responsibility under section 118(i) of the HPCA Act. It is not an optional add-on; it is fundamental to quality and safe care. Our role as a regulator includes embedding cultural safety across all stages of the professional lifecycle, from education and registration to ongoing development.
12. A case investigated by the Health and Disability Commissioner (HDC) further demonstrates the importance of cultural safety in clinical practice. In this instance, a Cook Islands Māori woman receiving mental health services from Counties Manukau District Health Board was not offered a cultural assessment or support, despite multiple opportunities over three months. Her cultural identity and needs were not acknowledged or incorporated into her care plan. The woman was later found unconscious at home and tragically passed away. The HDC found the DHB in breach of the Code for failing to provide services that considered the values and beliefs of the consumer. This case illustrates that cultural safety must be actively embedded, not simply assumed, to avoid causing harm.[3]

Streamlined Regulation

13. We support practical collaboration that enhances efficiency and improves access, provided it does not compromise professional standards or RA independence. Our co-location with 11 other RAs demonstrates that shared services can increase value without sacrificing autonomy. This includes (but not limited to) shared premises, informal peer support, and collaborative projects.
14. We are open to shared digital infrastructure, such as a centralised public register or IT system, if developed collaboratively and appropriately funded. A well-designed platform enables the public to easily verify practitioner credentials and registration status across professions, offering transparency and accessibility while reinforcing trust in the regulatory system. For example, a "Find My Practitioner" platform could improve public access to registration data while preserving each RA's professional identity.
15. Efforts to align frameworks, such as those for ethics, conduct, and boundaries, can promote consistency. However, such efforts must allow for flexibility to reflect profession-specific values and contexts.

[3] Health and Disability Commissioner. (2022). Mental health services – Failure to provide culturally appropriate care – Case 20HDC00354. Retrieved from https://www.hdc.org.nz/decisions/search-decisions/2022/20hdc00354/

16. Centralising all regulation under one body risks losing professional insight, agility, and responsiveness. The existing model supports strong relationships between RAs and the professions they regulate.
17. While we are committed to exploring deeper collaboration, we do not believe amalgamation is in the public's best interest. Maintaining profession-led regulation is essential for ensuring responsiveness, cultural safety, and standards that are appropriate to each scope of practice.

Right-Sized Regulation

18. There is a misalignment between how risk is presented in the consultation document and how it is understood by RAs. RA risk assessments focus on clinical safety, competence, conduct, and practitioner fitness to practise. The consultation's broader interpretation, which includes workforce supply and system efficiency, reflects policy concerns rather than regulatory mandates.
19. If a tiered model is proposed, it must be underpinned by a transparent risk matrix co-designed with the RAs. This matrix should account for clinical complexity, public impact, and practitioner supervision requirements.
20. Credentialling or certification models may have value in low-risk contexts, but they must not be used to justify deregulation. Public protection must remain paramount.
21. The argument that smaller RAs are inefficient is unsubstantiated. Our size allows us to remain agile, engaged, and accountable. Without a clear definition of what constitutes a "small RA," conclusions drawn on scale alone are unhelpful; regulatory performance should be assessed on outcomes.

Future-Proofed Regulation

22. The regulatory system must be equipped to respond to innovation. The HPCA Act allows RAs to develop and revise scopes of practice, set registration standards, and recognise new qualifications or practice models.
23. We support direction-setting from the Ministry, but caution against any shift that would enable political influence over individual registration or disciplinary decisions. Independence is essential for fair, credible, and consistent regulation. Any direction from the Minister or Ministry needs to be achievable.
24. We support credentialling models that enable task-sharing and role evolution, where they are consistent with public safety and cultural competence standards.
25. Workforce planning must be a shared endeavour. RAs can contribute valuable data and insights while retaining their regulatory independence. We welcome collaborative approaches with Te Whatu Ora, the Ministry, education providers, and sector stakeholders.
26. While we recognise the importance of improving service access and availability, many of the drivers of workforce pressure, such as wages, immigration settings, and funding, sit outside the control of RAs. RAs must remain focused on their statutory mandate: ensuring that health professionals are competent, culturally safe, and fit to practise.
27. Efforts to align regulatory decisions with system-level workforce goals must be proportionate and realistic. The public must be able to trust that RA decisions are not

compromised by pressures RAs are not resourced or empowered to resolve. We welcome collaboration with system planners, but not in ways that risk weakening standards or undermining independence.

Lessons from Other Sectors

28. Other sectors provide cautionary examples about the risks of over-centralisation. The Te Pūkenga merger aimed to streamline vocational education but quickly faced issues, financial instability, leadership turnover, and diminished responsiveness to local communities. These outcomes prompted a return to regionalised models.
29. Te Whatu Ora, formed by merging 20 DHBs into one national body, also faced concerns over bureaucracy, workforce morale, and reduced connection to local needs.
30. Australia's Ahpra model, often cited as a regulatory benchmark, has similarly faced criticism, from complexity in processes to limited engagement with some professional groups.
31. These experiences reaffirm the value of independent, profession-specific regulation, tailored to context, responsive to change, and accountable to the public.
32. We do not support the amalgamation of RAs, whether partial or full, as it risks undermining public safety, profession-specific accountability, and cultural responsiveness. Instead, we recommend targeted collaboration that strengthens existing systems without compromising autonomy.

6. Recommendations

1. **Preserve independent, profession-led regulation** tailored to each profession.
2. **Encourage collaboration** across RAs through shared platforms, policies, and infrastructure, while safeguarding autonomy.
3. **Support development of a centralised public-facing register** that links to RA-specific information and supports transparency, accessibility, and public confidence.
4. **Establish a national consumer rōpū** to support inclusive, cross-sector public engagement.
5. **Clarify the definition of regulatory risk** through a co-designed matrix that reflects clinical and cultural dimensions.
6. **Develop shared regulatory frameworks** (e.g., ethics, boundaries, professional conduct) that maintain flexibility for profession-specific values and context.
7. **Support shared workforce planning** efforts while ensuring RAs retain the ability to regulate in line with their scopes and sector needs.
8. **Assess RA effectiveness based on outcomes**, not size or registrant numbers, and recognise the strengths of smaller, agile regulators.
9. **Retain cultural competence** as a legislated standard under the HPCA Act.
10. **Avoid reforms that increase the risk of political influence over regulatory decisions**.

Ngā mihi nui,

NEW ZEALAND
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