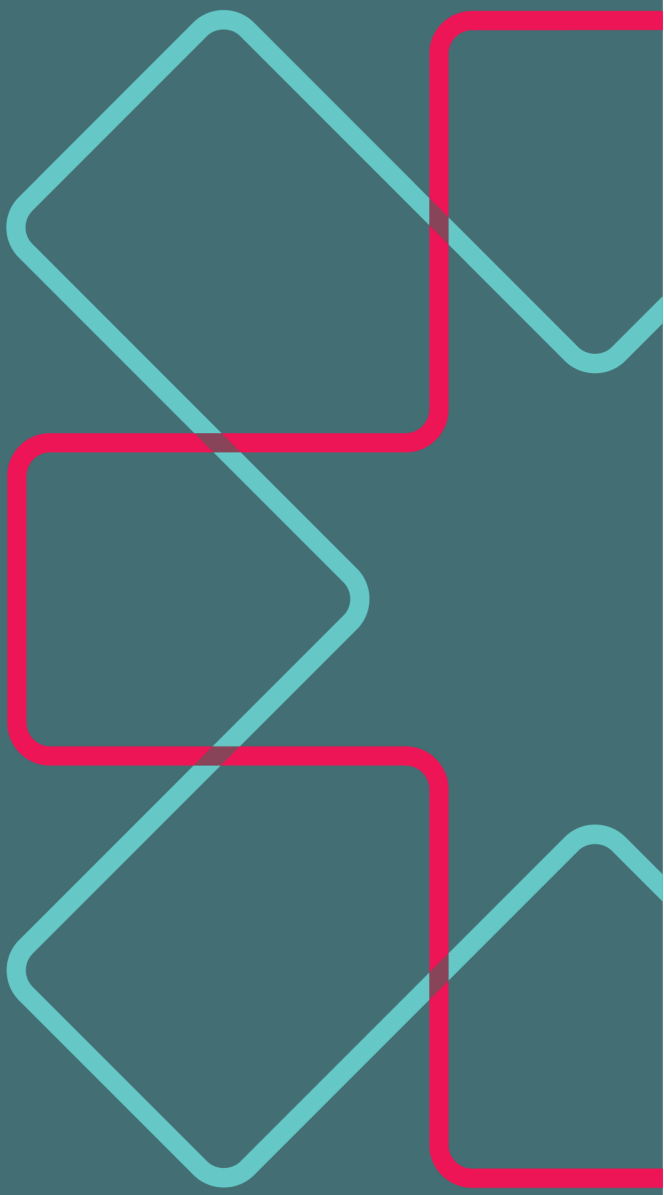
Addressing public safety for category 3 workers (social work-like workers)

For Social Workers Registration Board
Final Report



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01 November 2023
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Preface

This report has been prepared for Social Workers Registration Board by EeMun Chen and Ben Guernier from MartinJenkins (Martin, Jenkins & Associates Ltd).

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Executive summary

The Social Workers Registration Board (SWRB) is undertaking work to better understand "social work-like" roles, including considering how public safety could be strengthened. This follows Cabinet agreement to fund the SWRB to undertake a one-off project to engage with, scope, and identify public safety considerations for the category 3 workforce.

Category 3 workers (defined for the purposes of the pay equity claim[1]) undertake work that is substantially similar and proximate to registered social workers. They are not registered themselves and receive varying levels of supervision and oversight from registered professionals (eligible to be registered, but not necessarily registered), including registered social workers.

This report examines how public safety is addressed in analogous professions in Aotearoa New Zealand, and in "social work-like" professions internationally. This may be through various forms of regulation or other interventions. The report draws on:

- a desktop review of regulation and interventions for professions in England, Wales, and Ontario, Canada, and regulation of engineering associates, legal executives, and enrolled nurses in New Zealand
- a brief literature review, and
- discussions with occupational regulation[2] policy officials at the Ministry of Health and Ministry of Business, Innovation and Employment.

The Cabinet Office Policy Framework for Occupational Regulation and The Treasury's guidance on good regulatory practice provide useful frameworks for consideration of any intervention to address the risk of harm through occupational practice. It requires a clear problem identification, clear objectives, and an understanding of the efficiency, effectiveness, benefits, and costs of the full range of intervention options that could solve the problem. If significant harm is likely and existing means of protection are insufficient, then there is a strong case for intervention. Interventions should be focused on policy outcomes and be proportionate to the risk.

Occupational interventions and regulation seek to address safety through improving and assuring the quality of practice. However, it can also have impacts on practice, the workforce, and the broader system. This can include adding complexity and costs to the system, and hindering workforce innovation and optimisation. Implications for indigenous and other specific populations, and practices, also require consideration.

There are a wide variety of approaches used to address risk of harm in occupational practice both in Aotearoa and internationally. Approaches vary in their:

[1] In 2019, the Public Service Association raised a claim with five NGOs for social workers and people doing the same or substantially similar work. This identified four categories of work: Category 1: Registered social workers; Category 2: Registered professionals (but not registered social workers) employed in a social work role; Category 3: Professionals undertaking work substantially similar to social work, but not regulated; and Category 4: Registered social workers or other registered professionals leading social work practice.

[2] Occupational regulation refers to rules and often laws to protect the public from the risks of an occupation being carried out incompetently or recklessly.

- form (self-regulation, direct statutory regulation, co-regulation, and meta-regulation)
- regime type (disclosure, registration, certification, licencing or accreditation), and
- use of interventions (provision of information to consumers, training of practitioners, setting and enforcing standards, specifying the services government will purchase, and organisational performance monitoring and management).

The analysis suggests four areas for further consideration:

1. **Further consideration could be given to what interventions are proportionate and warranted, depending on the articulation of and evidence base on the policy problem related to category 3 workers**. The size and scale of public safety concerns appear to be unknown. However, initial work by the SWRB suggests that category 3 workers are likely to be working with populations experiencing vulnerability.[3] Work on the nature and scale of the risk posed by the practice of category 3 workers is required before further design work is undertaken on possible interventions.[4]
2. **Further work on the definition of category 3 workers may be required.** The work undertaken to date suggests that the qualifications for category 3 workers are varied, and the competencies and standards also vary. Category 3 workers may not be a cohesive enough profession suitable for regulation.
3. **The costs related to regulation for category 3 workers may outweigh the potential benefits, although this should be explored further**. Benefits could include the avoidance of significant harm and the costs related to unsafe practice.[5] This needs to be weighed against costs to government and the costs to service users, which are of particular concern in the social services sector and for the category 3 workforce – many of whom are likely to be low paid. Most occupational regulation impose high costs on the system, government, and the public.
4. **Existing mechanisms should be assessed to the extent they already address the risk to public safety**. Existing mechanisms could be further tested as to whether they could be used, or modified, to manage public safety in relation to category 3 workers. Examples include:
    - Te Kāhui Kāhu and whether requirements are sufficient to provide oversight and monitoring of the practices of category 3 workers, and
    - requirements for registered social workers, and whether supervision of category 3 workers should be, or could be, specified in existing legislation or regulation.

[3] The SWRB survey found that category 3 workers work with in child, youth, and whānau support; mental health; and whānau/family violence.

[4] The resulting problem definition may closely reflect the problem definition articulated for the regulation of social workers in terms of the nature of risk that can arise from social work practice. Further work on problem definition may consider how this risk applies to the category 3 workforce.

[5] We note that quantification of costs and benefits are difficult to confirm due to lack of cross-agency data and information-sharing, and benefits are often intangible or non-financial, However, some articulation of the costs and benefits of regulation need to be considered when determining what interventions may be proportionate and warranted.

Context

The Social Workers Registration Board is the regulator of social workers

1. The Social Workers Registration Board (SWRB) is a Crown entity and is the regulatory authority responsible for the registration of social workers (under the Social Workers Registration Act 2003). The Ministry of Social Development is the administrator of the Act.

2. The SWRB's primary functions are to: protect the safety of members of the public by ensuring that when social workers come onto the register, they are competent, fit to practise, and will be accountable for the way in which they practise; and to enhance the professionalism of social workers.

3. In 2019, the Social Workers Registration Act 2003 was amended to make it mandatory for anyone calling themselves a social worker and practising in New Zealand to be registered with the SWRB.[6] This replaced the voluntary registration system, which was considered no longer adequate to ensure the level of professionalism needed in the social work sector, with there being high risks associated with poor social work practice.[7]

A pay equity settlement for social workers was reached in 2018 and was later extended to category 3 workers, who were doing the same or substantially similar work to registered social workers

4. In 2018, Oranga Tamariki social workers reached a pay equity settlement resulting in an average pay correction of 30%. Social workers employed by NGOs delivering social, health, and education services on behalf of the Crown were not covered. In 2019, the Public Service Association raised a claim with five NGOs for social workers and people doing the same or substantially similar work. This identified four categories of work:

    - Category 1: Registered social workers.
    - Category 2: Registered professionals (but not registered social workers) employed in a social work role.
    - Category 3: Professionals undertaking work substantially similar to social work, but not regulated.

[6] Social Workers Registration Legislation Act 2019.

[7] Regulatory Impact Statement: Legislative changes to increase the professionalism of the social work workforce (2017) states "There is a small but significant risk of serious harm to clients from incompetent social work because of the nature and circumstances of the client group and the range of interventions delivered by social workers. Incompetent practice can cause immediate harm and the impact may also be long lasting. That is why skilled, well-trained professionals are required". https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/regulatory-impact-statements/swra-ris.pdf.

- Category 4: Registered social workers or other registered professionals leading social work practice.

5. In November 2022, Cabinet agreed to extend the pay equity benefits to all social workers and other workers undertaking substantially similar work in community and iwi organisations.

SWRB was directed by Cabinet to consider public safety considerations for the category 3 workforce

6. At the same time, Cabinet agreed to fund the SWRB to undertake a one-off project to engage with, scope, and identify public safety considerations for the category 3 workforce. This was recognition that very little is known about this unregulated workforce, despite the risks of poor practice being the same as for registered social workers.

Definition of category 3 workforce

7. This workforce is defined using the following criteria:

> To be included as a category 3 workers, an employee must:[8]
>
> a. have 80% or more of their day-to-day work that overlaps with registered social workers; **and**
>
> b. receive supervision or oversight from a registered social worker or registered/registrable professional; **and**
>
> c. not do any of the following as their main task: budget advice, financial mentoring, community navigation, youth work, administration, and needs assessment.

8. Some useful insights on the category 3 workforce were gathered through meetings with government and NGO sector leaders and subject matter experts, and a survey of 200 workers and employers identified by Te Kawa Mataaho Public Service Commission in the pay equity work. While the insights were not representative of the workforce, they provide some useful context for the likely category 3 workforce:

- Commonly used job titles included whānau/family support worker, kaiwhakahaere[9], kaimahi[10], advocate, coordinator, and mentor.
- Tended to work in child, youth, and whānau support; mental health; and whānau/family violence.
- May have substantial experience or community/iwi-based connections in roles where professional registration is not a requirement. They were strongly connected to and accountable to the community.

[8] Public Services Commission. (2022). *Who is covered by the social work pay equity extension?* https://www.publicservice.govt.nz/assets/DirectoryFile/Who-is-covered-categories-of-work.pdf

[9] Translates to council, advocate, agent, advisor.

[10] Translates to worker, employee, clerk, staff.

- Drew on practice frameworks including social work, community, or te ao Māori frameworks to undertake work that is substantially similar to social work.
- Worked with supervision or sign-off requirements for clinical decision-making, but frequency and quality of supervision were highly variable.
- Most workers worked within environments where there was a complaints process in place.
- Had a range of qualifications, with around half qualified at bachelor's level and some with social work qualifications. A role may require a body of knowledge for specific context, for example, homelessness.

Purpose of this report: The SWRB needs to understand how public safety could be addressed in the category 3 workforce

9. The SWRB has commissioned this research to focus on two questions:
    a. In Aotearoa New Zealand, how are public safety concerns addressed for professions that undertake substantially similar work to another regulated profession?
    b. Internationally, how are public safety concerns addressed for professions that undertake similar work to social work?

Scope

10. The report identifies key considerations when examining the potential for occupational regulation in the health and social care sectors, and the various regulatory approaches that can be taken to address the risk of harm. This is exploratory analysis that will be an input into SWRB's overall programme of work on the category 3 workforce.
11. It does not provide analysis of the options or recommendations on what the regulatory approach should be.

Method: This report is based on a desktop review, interviews with policy officials focused on occupational regulation, and the development of six case studies

12. A desktop review based on the research questions, key search terms, and countries and professions of interest was undertaken. Key sources included Cabinet and policy papers for other professions, and national/federal government agency websites (for example, Social Work England and Northern Ireland Social Services Council).
13. We interviewed two government departments responsible for occupational regulatory policy:
    - Ministry of Business, Innovation and Employment (MBIE) for the policy considerations underpinning the new engineering regulator, and
    - Ministry of Health for health workers.

Case studies

14. In consultation with SWRB, the following jurisdictions and professions were selected:

Jurisdiction	Why analogous	Overview
England	• Common history and similar institutions. • Regulator for social workers and social care providers.	• Social Work England regulates social workers. • Care Quality Commission (CQC) regulates **providers** (rather than the worker) in both the health and social care sector, Providers are required to register with the CQC who assesses provider performance, and investigates and addresses concerns of poor quality among organisations delivering care (in association with local authorities).
Wales	• Common history and similar institutions. • Regulator regulates social workers and social care workers.	• Social Care Wales registers social workers and social care workers.
Ontario, Canada	• Similar institutions. • Indigenous population and workers. • Regulator regulates social workers and social service workers.	• Ontario College of Social Workers and Social Service Workers is the regulator. • Social Work and Social Service Work Act 1998 restricts the use of the following title(s): – Social Worker/ Registered Social Worker (generally, holders of degrees: Bachelor of Social Work, Master of Social Work, Doctor of Social Work). – Social Service Worker/Registered Social Service Worker (generally, holders of a two-year certificate in social services from a community college).

Professions		
Legal executives	• Primarily self-regulated with aspects of co-regulation due to statutory recognition that registered legal execs can do certain tasks.	• New Zealand Institute of Legal Executives is the professional association. • There are registered legal executives, but there is no statutory protection of the title "Legal Executive". • Registration differentiates qualified and experienced legal executives from non-members whose firms call their staff legal executives, but who may or may not be qualified or even doing the work of a legal executive. • Registered legal executives are entitled to associate membership of the New Zealand Law Society.
Enrolled nurses	• Registered and enrolled nurses are regulated under the Health Practitioners Competence Assurance Act (HPCA) 2003. • In 2016, nurse practitioners were introduced and are also regulated under the HPCA 2003.	• The category includes enrolled nurses, registered nurses, and nurse practitioners.
Engineering associates	• On 24 March 2022, MBIE announced agreement to progress with a new regulatory regime for professional engineers.	• MBIE is to introduce a bill for a new two-tiered regulatory regime for engineers, and to establish a new regulator to oversee the regime. • This will require all persons practising in high-risk fields to be licensed, including registered engineers. However, it will be voluntary for registered engineering associates.

15. Further detail on the regimes of each of these jurisdictions and professions is in Appendix 1.

Defining key concepts: scopes of practice and title protection

Scopes of practice

16. A scope of practice defines what a profession does. While the term is commonly used in occupational regulation, there is no consistent definition. It is generally used to describe the "roles, functions, tasks and activities, professional competencies, standards of practice, entry to practice, registration requirements, the practice of medicine (such as nursing or pharmacy), domains of practice, scope of employment, or scope enactment".[11]

17. It is often referred to as the full range of roles, responsibilities, functions, and tasks that those working within a particular profession are allowed to perform, taking into account their qualifications and competence. A scope of practice is described as an "important concept for health regulators, leaders, and managers and has long been central to system-level health workforce reform."[12]

18. The Ontario College of Social Workers provides the following for a scope of practice: "articulating a scope of practice for a profession is a critical regulatory function. Typically, a scope of practice is a description of a profession's activities, including the boundaries of these activities, especially in relation to other professions where similar activities may be performed."[13]

Title protection

19. Title protection means only certain people are able to call themselves a certain job title. The title "social worker" is protected. That means only social workers who are registered by the SWRB can use the title "social worker". Title protection was introduced in February 2021 at the same time as mandatory registration.

20. Title protection for social workers used the Health Practitioners Competence Assurance Act 2003 (HPCA Act) as a model which uses an approach centred on certification and title protection. Title protection protects the public interest by providing patients, clients, and consumers with clear ways to identify whether a practitioner has the minimum qualifications and are competent and safe to practice. Title protection is often accompanied with offences for false representation.

21. Te Kāhui Kāhu takes the lead on responding to concerns about anyone who is presenting or practicing as a social worker but is not registered as a social worker. Concerns about the competence or actions of a non-registered worker need to be directed to their employer.

[11] Baranek, P. M. (2005). *A review of scopes of practice of health professions in Canada: A balancing act*. Health Council of Canada hcc_scope-of-practice_200511_e.qxp (publications.gc.ca) (p. 6)

[12] Downie, S, Walsh, J, Kirk-Brown, A, & Haines, T P. (2023). How can scope of practice be described and conceptualised in medical and health professions? A systematic review for scoping and content analysis. *International Journal of Health Planning and Management, 38*, 1184-1211.How can scope of practice be described and conceptualised in medical and health professions? A systematic review for scoping and content analysis - Downie - 2023 - The International Journal of Health Planning and Management - Wiley Online Library

[13] Ontario Collee of Social Workers and Social Service Workers. (2008). Position Paper on Scopes of Practice. https://www.ocswssw.org/wp-content/uploads/Position-Paper-on-Scopes-of-Practice-2018-revised-20180626.pdf.

Policy framework for occupational regulation

This section sets out the *Cabinet Office Policy Framework for Occupational Regulation*, for determining whether and how to address public safety in an occupation.

Ensuring safety through occupational practice is an enduring challenge

22. Unethical or incompetent occupational practice can seriously harm people, particularly in the social care and health systems.[14] Unfortunately, this is typically highlighted through serious incidents, inquiries, and investigations. For example, in the UK this has included high profile inquiries into child abuse and murder in the social care system, and in New Zealand safe practice and quality of care have been raised in the Abuse in Care Royal Commission of Inquiry, the Joint Review into the Children's Sector[15], and the rapid review of Oranga Tamariki Youth Justice and Care and Protection Residences.[16]

23. Identification of significant issues and risks is typically the key driver for introducing occupational regulation. For example, high profile inquiries in the UK have led to regulatory reform in the social care sector[17] and in New Zealand, the collapse of the CTV building during the Christchurch earthquakes resulted in government involvement in the regulation of engineers.[18]

24. The Cabinet Office circular provides that the aim of regulating occupations is "to protect the public from the harm that could be caused by incompetent, reckless, or dishonest practice of an occupation".[19]

[14] Ontaria, Canada Ministry of Community & Social Services. (2005). *Review of the Social Work & Social Service Work Act 1998 – Discussion paper*. Ministry of Community & Social Services. Microsoft Word - SWConsultation Paper-revised 3_oct25_DR_RL.doc (ocswssw.org)

[15] Poutasi, H. (2022). *Ensuring strong and effective safety nets to prevent abuse of children. Joint Review into the Children's Sector: Identification and response to suspected abuse*. Final-report-Joint-Review-into-the-Childrens-Sector.pdf (orangatamariki.govt.nz)

[16] Francis, D. & Vlaanderen. (2023). *Oranga Tamariki secure residences and a sample of community homes (independent, external rapid review)*. Secure-residence-review.pdf (orangatamariki.govt.nz)

[17] Jones, R. (2020). 1970-2020: A fifty-year history the personal social services and social work in England and across the United Kingdom. *Social Work & Social Sciences Review*, *21*(3), 8–44. https://journals.whitingbirch.net/index.php/SWSSR/article/view/1495

[18] Canterbury Earthquakes Royal Commission. (2012). *Volume 5: Summary and Recommendations in Volumes 5 - 7, Christchurch, the city and approach to this inquiry* https://canterbury.royalcommission.govt.nz/Final-Report---Part-Three

[19] Cabinet Office. (1999). *Policy framework for occupational regulation*. Cabinet Office Circular, CO (99) 6. Cabinet Office Circular CO (99) 6: Policy Framework for Occupational Regulation - 8 June 1999 (dpmc.govt.nz) (p. 4).

Any intervention requires careful and principled consideration

25. Occupational regulation has the potential for addressing public safety but also imposing costs and broader implications on the system.

26. Cabinet Office has provided a framework for identifying interventions to manage occupational harm.[20] This framework provides the key considerations for any regulatory intervention. These are a clear problem identification and objectives, and an understanding of the efficiency, effectiveness, benefits, and costs of the full range of intervention options that could solve the problem. If significant harm is likely and existing means of protection are insufficient, then there is a strong case for intervention. Interventions should be focused on outcomes and be proportionate to the risk.

27. These principles are supported by the *Government Expectations for Good Regulatory Practice*[21] which emphasise the importance of clear objectives and achieving those in a least cost way, while ensuring flexibility, accountability, and proportionality, along with a range of other considerations. These principles are applied internationally, and particularly in social care and health regulation.[22]

The Cabinet Office has a policy framework for occupational regulation

28. Cabinet Office's policy framework assumes:

    a. intervention by the government in occupations should generally be used only when there is a problem or potential problem that is either unlikely to be solved in any other way or inefficient or ineffective to solve any other way

    b. the amount of intervention should be the minimum to solve the problem, and

    c. the benefits of intervening must exceed the costs.

[20] Cabinet Office. (1999). *Policy framework for occupational regulation*. Cabinet Office Circular, CO (99) 6. Cabinet Office Circular CO (99) 6: Policy Framework for Occupational Regulation - 8 June 1999 (dpmc.govt.nz)

[21] New Zealand Treasury. (2017). *Government expectations for good regulatory practice*. https://www.treasury.govt.nz/sites/default/files/2015-09/good-reg-practice.pdf

[22] Leslie, K., Moore, J., Robertson, C., Bilton, D., Hirschkorn, K., Langelier, M. H. & Bourgeault, L. (2021). Regulating health professional scopes of practice: comparing institutional arrangements and approaches in the US, Canada, Australia and the UK. *Human Resources for Health, 19*(15) https://doi.org/10.1186/s12960-020-00550-3 https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-020-00550-3#:~:text=The%20principles%20of%20right%2Dtouch,the%20public%20interest%20%5B18%5D.

29. The framework provides a decision-making process for determining government involvement in occupational regulation:

Step one	Identify whether intervention of an occupation is necessary	• Consider the nature of the risk from the occupation: – probability of significant irreversible harm occurring, and – availability of other means of handling risk (for example, insurance). • If significant irreversible harm is likely there is a case for intervention in the practice of the occupation.
Step two	Identify whether intervention by government is justified	• Consider whether existing means of protection from harm for consumers and third parties are sufficient (for example, civil law, consumer legislation). • Consider ability of industry to regulate itself. • Consider likely effect of intervention by government. • If significant harm is likely, existing means of protection are insufficient, the industry is unable to regulate itself adequately and intervention by government is likely to improve outcomes, there is a strong case for government intervention.
Step three	Identify the most effective form of government intervention	• Consider nature of problem posed by the occupation. Would it be solved by: – provision of information to consumers – training of practitioners – setting and enforcing standards – specifying services government will purchase, and – legislation regulating practice of occupation. • If only a specific aspect of the practice of an occupation poses a threat to consumers or third parties, the best solution is to target that aspect rather than legislate to regulate the occupation.
Step four	If legislation is required, what form of regulatory regime is needed?	• Consider other forms of regulatory regime, if needed, including: – disclosure – registration – certification, and – licensing those entering an occupation. • Licensing workers in an occupation imposes costs and reduces flexibility more than other means of control and should be reserved for occupations where there is a high need for control for safety reasons. Any of the other methods are likely to be adequate control for occupations, which do not affect health or safety.
Step five	What legislative provisions are needed to regulate occupations?	• Refer to model legislation for examples of best practice regulation for the different types of regulatory control.

Application of the framework to category 3 workers

30. This report applies the framework to category 3 workers by traversing:

    a. key considerations and implications of occupational regulation – to assist in issues identification for regulating category 3 workers

    b. various approaches and interventions for occupational regulation – to assist in understanding how existing means might apply, and what new or amended approaches may be available for category 3 workers, and

    c. how regulation has been applied to workers that are analogous to category 3 workers in other jurisdictions internationally and in New Zealand.

Analysis: Application of the occupational regulatory framework to category 3 workers

This section goes through the initial four steps of the policy framework for occupational regulation, with reference to the case studies, to determine the best approach for category 3 workers. The last step (step five) covers legislative provisions and is not in scope of this report.

Step one: Identify whether intervention of an occupation is necessary

The threshold for regulation is usually risk of *significant* harm

31. The key driver behind the introduction of workforce regulation is the potential for the practitioner to cause significant harm – "Delivering safe and effective care will continue to be the driving principle behind professional regulation".[23]

32. As outlined in the Cabinet Office circular, this harm needs to meet a threshold of *significant* harm: "given the compliance costs of intervening in occupations, it is important to limit intervention to cases where the harm has the potential to be significant... Nearly all occupations have the capacity to cause harm that is not significant".[24]

33. This is illustrated in examples of government's considering whether the level of risk warrants intervention:

    - In Ontario, Canada, regulation of psychotherapy was introduced as the "risk of harm" was considered serious enough.[25]
    - The UK Select Committee considered the introduction of licencing for youth work and found that here was "not sufficient evidence to convince us of the merits or otherwise of introducing a licence to practice for youth work". The Committee noted proposals for an Institute of Youth Work for setting minimum standards and continuing professional development (CPD) was worth further investigation.[26]

[23] England Department of Health. (2011). Enabling excellence: Autonomy and accountability for healthcare workers, social workers and social care workers. Cm 8008 Enabling Excellence (publishing.service.gov.uk)

[24] Cabinet Office. (1999). *Policy framework for occupational regulation*. Cabinet Office Circular, CO (99) 6. Cabinet Office Circular CO (99) 6: Policy Framework for Occupational Regulation - 8 June 1999 (dpmc.govt.nz). (p. 6).

[25] Ontario Health Professions Regulatory Advisory Council. (2006). *Regulation of health professions in Ontario: New directions*. Regulation of Health Professions in Ontario: New Directions (hmac.ca)

[26] England Select Committee Inquiry (2011). *Services for young people – education*. https://publications.parliament.uk/pa/cm201012/cmselect/cmeduc/744/74409.htm

- A similar assessment was undertaken by the English Department of Health for proposed regulation of social care workers, which also considered the availability of other means to address safety:

> *"In many cases, the risk to service users and the general public posed by groups of unregulated health and social care workers is not considered to be such that regulation of individual workers is necessary, given the wider safeguards within the system, such as the Vetting and Barring Scheme in England and Wales and the regulation of most providers of health and social care services. In general terms, the Government does not believe that the extension of statutory regulation to all workers in the health sector across the UK and the social care sector in England would be a proportionate response."*[27]

34. The Ministry of Health's guidelines for health professions to be considered for regulation under the Health Practitioners Competence and Assurance Act 2003 is a useful one to consider for category 3 workers.[28] Under that Act, the Minister must be satisfied that the services pose a risk of harm to the public or that it is otherwise in the public interest that the service be regulated.

35. In determining risk of harm to the public, members of the profession must be involved in at least two of the following activities:

    - Invasive procedures (including but not limited to cutting under the skin or inserting objects into the body).
    - Clinical intervention with the potential for physical or mental harm.
    - Making decisions or exercising judgement which can substantially impact on patient health or welfare, including situations where individuals work autonomously, that is unsupervised by other regulated health professionals.

36. Harm may include death, disablement, or permanent negative change in a person's physical or mental health status. It may also include indirect harm (for example, failing to refer a consumer on when warranted). Using the above criteria, analysis may focus on whether most category 3 workers meet the threshold for risk of harm based on the types of activities they undertake. This would require a deeper understanding of the nature of the types of work tasks and decisions being made by category 3 workers.

[27] England Department of Health. (2011). Enabling excellence: Autonomy and accountability for healthcare workers, social workers and social care workers. Cm 8008 Enabling Excellence (publishing.service.gov.uk)

[28] Ministry of Health. (2022). *Guidelines for applying for regulation under the Health Practitioners Competence Assurance Act 2003.* Microsoft Word - applying-for-regulation-under-the-hpca-2003-031220 v2022 (health.govt.nz)

37. In determining "risk of harm", consideration should also be given to:

    - the nature and severity of the risk to consumers (including groups of consumers experiencing vulnerability) who may lack the capacity to make decisions and understand the services they receive), and
    - the nature and severity of the risk to the wider public.

38. The case for potential interventions to address any risk in the category 3 workforce should be supported with evidence of the level of risk of harm posed by their services.

Public interest

39. If the "risk of harm" thresholds are not met, the Act recognises that there may be some instances where regulation may still be in the public interest. The guidance for health professions goes on to ask whether it is in the public interest that the health service be regulated as a profession. Examples of where this might apply are for professions that:

    - practise without the supervision or support of peers, managers, and other regulated health practitioners
    - are highly mobile, locum, or work on short tenure
    - are not guided by a strong professional (or employer) code of conduct
    - provide services to individuals experiencing vulnerability or isolation
    - are subject to such large numbers of complaints about the quality of services that oversight of competence from an independent body is required, and
    - carry out roles where the training and educational requirements are short and there is no extended period through which the ethos and values which underpin safe practice can be absorbed.

40. Further analysis should look at whether category 3 workers require interventions in the public interest.

What is the profession of interest?

41. The work and the profession must also be well-defined.[29] Service providers should be clear as to the:

    - qualifications for any class of providers of those health services
    - standards that any class of service providers are expected to meet, and
    - competencies for scopes of practice for those health services.

42. Table 1 further outlines whether regulation under the HPCA is possible to implement.

[29] Ministry of Health. (2022). *Guidelines for applying for regulation under the Health Practitioners Competence Assurance Act 2003.* Microsoft Word - applying-for-regulation-under-the-hpca-2003-031220 v2022 (health.govt.nz) ; McDonald, F. (2006). *Health Professional Regulatory Regimes: A Comparative Analysis, Report to Manitoba Health* https://www.gov.mb.ca/health/rhpa/docs/hprf.pdf

Table 1: Criterion 2 – Is regulation under the [HPCA] possible to implement for the profession in question?

This criterion is not intended to provide a loophole for a profession that meets the primary criteria for regulation to avoid regulation under the Act but any barriers to such regulation need to be identified and addressed. Matters that should be addressed may include, but are not limited to, any of the following:

- Does the profession have a defined body of knowledge that can form the basis for standards of practice?
- Is the profession well defined?
- Does the profession cover a discrete area of activity displaying some homogeneity?
- Is this body of knowledge, with the skills and abilities necessary to apply the knowledge, teachable and testable?
- Where applicable, have functional competencies been defined?
- Do the members of the profession require accredited qualifications?
- Is the practice based on evidence of efficacy?
- Are there defined routes of entry to the profession?
- Are there independently assessed entry qualifications?
- Are there standards in relation to conduct, performance, and ethics?
- Are there procedures to enforce those standards?
- Are the professionals committed to continuous professional development?
- What professional titles are used?

To establish this criterion, please provide evidence of how the qualifications, standards, and competencies that will be expected of practitioners will reduce the risk of harm to the public or help achieve the public interest.

Source: Ministry of Health. (2022). *Guidelines for applying for regulation under the Health Practitioners Competence Assurance Act 2003.*

43. Further work on regulation of category 3 workers should consider whether the workforce is sufficiently well-defined including through qualifications, specific bodies of knowledge, standards of practice, and scopes of practice.

44. In Wales, social care workers are defined in the legislation as being a person who:[30]

    - engages in relevant social work (social workers);
    - manages a place at or from which a regulated service[31] is provided;
    - in the course of his or her employment with a service provider, provides care and support to any person in Wales in connection with a regulated service provided by that provider; or
    - under a contract for services, provides care and support to any person in Wales in connection with a regulated service provided by a service provider.

45. In Ontario, Canada, social service workers assist clients in dealing with personal and social problems by delivering counselling, community services, and social support programmes. The "role of a social service worker" is defined by regulation as "a person who assesses, treats and evaluates individual, interpersonal and societal problems through the use of social service work

[30] Regulation and Inspection of Social Care (Wales) Act 2016, s 79.

[31] Regulation and Inspection of Social Care (Wales) Act 2016, s 2 defines "regulated service" as: a care home service, a secure accommodation service, a residential family centre service, an adoption service, a fostering service, an adult placement service, an advocacy service, a domiciliary support service, and any other service comprising the provision of care and support in Wales as may be prescribed.

knowledge, skills, interventions and strategies, to assist individuals, dyads, families, groups, organisations and communities to achieve optimum social functioning."[32] Social service workers must have an approved two-year diploma, which includes field placement.

46. The definition of category 3 workers in New Zealand, created for the purpose of the pay equity extension for social workers, specifically excludes some of the workers included in both Wales' and Canada's definitions.

Step two: Identify whether intervention by government is justified

Occupational regulation can have a range of benefits, but there can also be substantial costs and ongoing implications

47. While regulation has the potential to address safety issues and provide other benefits, it also has the potential for unintended consequences and negative impacts.[33] These are particularly acute in the social care sector, where practice is complex, evolving, interdisciplinary, and users are often populations experiencing vulnerability. At the same time, funding is limited and the workforce is tight.

48. Occupational regulation of health and social services has been subject to continual reform in the UK, New Zealand, Canada, and Australia.[34] Across these reforms, there are common themes that illustrate the key issues and considerations. These are well summarised by the objectives for the reform of healthcare professionals in the UK:[35]

    a. improve public protection from the risk of harm due to poor professional practice;

    b. support the development of a flexible workforce that is better able to meet the challenges of delivering healthcare in the future;

    c. address concerns about the performance of professionals in a more proportionate and responsive fashion;

    d. provide greater support to regulated professionals in delivering high quality care; and

[32] Ontario Collee of Social Workers and Social Service Workers. (2008). Position Paper on Scopes of Practice. https://www.ocswssw.org/wp-content/uploads/Position-Paper-on-Scopes-of-Practice-2018-revised-20180626.pdf.

[33] Ministry of Health. (2010). *How do we determine if statutory regulation is the most appropriate way to regulate health professions? Discussion document.* Wellington: Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/statutory-regulation-health-professions-discussion-document-jan10.pdf

[34] Discussion of reform in Ontario is provided in, Ontario Health Professions Regulatory Advisory Council. (2006). *Regulation of health professions in Ontario: New directions.* Regulation of Health Professions in Ontario: New Directions (hmac.ca); The Australian Government is currently reviewing its health practitioner regulatory settings. https://www.health.gov.au/our-work/independent-review-of-health-practitioner-regulatory-settings#:~:text=On%2030%20September%202022%2C%20National,who%20have%20studied%20in%20Australia.

[35] English Department of Health and Social Care. (2021). Regulating healthcare professionals, protecting the public. Regulating healthcare professionals, protecting the public (publishing.service.gov.uk). The Australian Government's current review of health practitioner regulatory settings review is focused on easing health workforce shortages while maintaining high standards in care quality and safety. https://www.health.gov.au/our-work/independent-review-of-health-practitioner-regulatory-settings#:~:text=On%2030%20September%202022%2C%20National,who%20have%20studied%20in%20Australia.

e. increase the efficiency of the system.

49. Occupational reform in the UK specified the benefit of "improved public perception of regulated professionals".[36] An expected benefit of social worker regulation in New Zealand was lifting the status of the profession.[37]

Regulation can have impacts on practice, the workforce, and broader system

Occupational regulation operates in a complex system

50. Beyond practitioners, the system comprises consumers, legislators, regulators, educators, and employers. There is a need to ensure any new regulation works for this system. This includes reflecting the needs of consumers and employers, corresponding with training and education, and allow practitioners to work to their full potential.[38]

51. Care should also be taken to not assume risks are addressed by another part of the system.[39]

Regulation can make the system confusing, inconsistent, and slow

52. Reforms to occupational regulation in the UK health system found that:

> *"from the perspective of patients and the public, the current system of regulation can be confusing, inconsistent and slow. People are not always clear which professionals are regulated by which regulatory body or against which standards. Staff working side by side in teams might be accountable to different bodies and working to different sets of standards. Different regulators might impose different sanctions for similar professional failings. Employers have to interact with numerous different professional regulators."* [40]

53. This complexity can also lead to difficulty of oversight and process that impacts care outcomes.[41]

[36] English Department of Health and Social Care. (2021). Regulating healthcare professionals, protecting the public. Regulating healthcare professionals, protecting the public (publishing.service.gov.uk); UK Commission for Employment and Skills. (2011). *A review of occupational regulation and its impact* (Evidence Report 40). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/306359/ER40_Occupational_regulation_impact_-_Oct_2011.pdf

[37] Ministry of Social Development. (2017). *Regulatory impact statement: Legislative changes to increase the professionalism of the social work workforce.* Legislative changes to increase the professionalism of the social work workforce, Including supplementary material on changes proposed for a Supplementary Order Paper - 12 February 2019 - Regulatory Impact Assessment - Ministry of Social Development (treasury.govt.nz)

[38] Baranek, P. M. (2005). *A review of scopes of practice of health professions in Canada: A balancing act*. Health Council of Canada hcc_scope-of-practice_200511_e.qxp (publications.gc.ca); Allison, M J. (2015). *The role of health profession regulation in health services improvement.* Thesis submitted to the Victoria University of Wellington in fulfilment of the requirements for the degree of Doctor of Philosophy thesis.pdf (vuw.ac.nz)

[39] The Francis Inquiry Report (2013) in the UK found that overlap in regulatory functions can lead to regulators assuming that the identification and resolution of specific issues are the responsibility of someone else.

[40] England Department of Health. (2017). *Promoting professionalism, reforming regulation: A paper for consultation.* Regulatory_Reform_Consultation_Document.pdf (publishing.service.gov.uk)

[41] Mid Staffordshire NHS Foundation Trust Public Inquiry. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf

Workforce shortage and costs are creating a drive to optimise the workforce, but regulation can be a barrier

54. Workforce optimisation can be achieved via collaborative practice and optimal use of teams. [42] In Australia, Canada, and the UK, a drive for rationalisation has encouraged changes to the workforce that include "substituting high-paid professional workers with health workers who could be paid less."[43] This requires an "understanding and agreement of not only who does what but also who should do what and why."[44]

55. This can occur through artificially limiting scopes of practice and prohibiting integration and interdisciplinary practice.[45] This can "prevent healthcare professionals from performing the full range of skills for which they have been trained, limit consumer access to care and choice of providers, and inflate the cost of healthcare."[46] It can also lift standards above the level which is really necessary.[47]

56. These challenges are illustrated by the recent changes to the NZ enrolled nurse scope of practice which were intended to "enable a more optimal scope of practice" and better reflect the relationship between the enrolled nurse, registered nurse, and wider healthcare team.[48]

57. The Australian Government is currently reviewing the barriers and incentives for health practitioners working to their full scope of practice in primary care.[49] Regulatory change in Australia has sought to improve workforce flexibility. As a result, "scopes of practice in this regulatory scheme are flexible, variable, and not clearly defined."[50]

[42] Baranek, P. M. (2005). *A review of scopes of practice of health professions in Canada: A balancing act*. Health Council of Canada hcc_scope-of-practice_200511_e.qxp (publications.gc.ca)

[43] Adams TL, Wannamaker K. (2022). Professional regulation, profession-state relations and the pandemic response: Australia, Canada, and the UK compared. *Social Science & Medicine, 296*:114808. Doi: 10.1016/j.socscimed.2022. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8837473/; Leggat, SG. (2014). *Changing health professionals' scope of practice: how do we continue to make progress?* Deeble Institute for Health Policy Research Issues brief (NLCG 4) Antimicrobial Resistance (ahha.asn.au)

[44] Baranek, P. M. (2005). *A review of scopes of practice of health professions in Canada: A balancing act*. Health Council of Canada hcc_scope-of-practice_200511_e.qxp (publications.gc.ca)

[45] Baranek, P. M. (2005). *A review of scopes of practice of health professions in Canada: A balancing act*. Health Council of Canada hcc_scope-of-practice_200511_e.qxp (publications.gc.ca); Dower, C, Moore, J & Langelier, M. (2013). It is time to restructure health professions scope-of-practice regulations to remove barriers to care. *Health Affairs, 32*(11). It Is Time To Restructure Health Professions Scope-Of-Practice Regulations To Remove Barriers To Care | Health Affairs; Frogner, EP Fraher, J Spetz, P Pittman et al. (2022). Modernizing scope-of-practice regulations-time to prioritize patients. *New England Journal of Medicine, 382*(7), 591-593. Modernizing Scope-of-Practice Regulations.pdf (ucsf.edu)

[46] Dower, C, Moore, J & Langelier, M. (2013). It is time to restructure health professions scope-of-practice regulations to remove barriers to care. *Health Affairs, 32*(11). It Is Time To Restructure Health Professions Scope-Of-Practice Regulations To Remove Barriers To Care | Health Affairs;

[47] Fells, A. (2001*). Regulation, competition, and the professions*. Industry Economics Conference – Australian Competition and Consumer Commission. https://www.accc.gov.au/system/files/Fels_Industry_Economics_14_7_01%5B1%5D.pdf

[48] Nursing Council of New Zealand. (2022). Consultation document, Review of the enrolled nurse scope of practice scope statement. https://www.nursingcouncil.org.nz/Public/Nursing/Scopes_of_practice/Enrolled_nurse/NCNZ/nursing-section/Enrolled_nurse.aspx?hkey=963854c0-246c-4bb1-800c-920a19b022dc

[49] Australian Government Department of Health and Aged Care. (2023). *Unleashing the potential of our health workforce – Scope of practice review*. Unleashing the Potential of our Health Workforce – Scope of practice review | Australian Government Department of Health and Aged Care

[50] Adams TL, Wannamaker K. (2022). Professional regulation, profession-state relations and the pandemic response: Australia, Canada, and the UK compared. *Social Science & Medicine, 296*:114808. doi: 10.1016/j.socscimed.2022. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8837473/

58. The New Zealand Productivity Commission has found that regulation can impact entry for volunteers who are particularly important for social services.[51]

Regulation can hinder innovation and changes in practice

59. During the reform process in Ontario, Canada, it was specifically noted that "the existing regulatory system did not contemplate the emerging trend toward multidisciplinary and collaborative practice."52 Similarly, a review of the regulatory framework for registered health professions in Victoria, Australia found:

    "Existing professions' specific registration legislation and governance structures reinforce rather than break down professional boundaries and do not foster a multi-disciplinary, flexible and responsive workforce. This makes workforce change in response to evolving service and client needs contested and slow. At the same time, the existing regulatory model does not facilitate good linkages between mechanisms that ensure practitioner quality with those that ensure system quality."[53]

60. Additionally, regulation can easily become obsolete by not keeping up with changes in technology, technological disruption, or changes in public expectations.[54]

Regulation can also impose costs on system participants, including practitioners and employers

61. Regulation is not cost-neutral. Costs arise from regulatory functions including establishment of the regulator itself, as well as ongoing processing, investigation, and checking. Practitioners and employers usually bear the burden of meeting requirements, which may include time and costs on administration, education, training, and CPD.

    a. **Practitioners:** Costs associated with regulation are usually met by participants in the occupation, in both time and fees. In the UK, regulation of the social care workforce was considered but ultimately not proceeded with, in part due to the costs on low paid workers.[55]

    b. **Employers:** Costs to employers can arise from the regulated practitioner passing on costs to their employer.[56] In the health and social sector, it is usually the government who bears the cost impact.

[51] New Zealand Productivity Commission. (2015). More effective social services. More effective social services (productivity.govt.nz)

[52] Ontario Health Professions Regulatory Advisory Council. (2006). *Regulation of health professions in Ontario: New directions*. Regulation of Health Professions in Ontario: New Directions (hmac.ca)

[53] Victoria Department of Human Services. (2005). *Review of regulation of the health professions in Victoria: Options for structural and legislative reform*. https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/research-and-reports/r/review_optionspaper_apr05.pdf

[54] New Zealand Productivity Commission. (2014). *Regulatory institutions and practices* (cut to the chase). https://www.productivity.govt.nz/assets/Documents/add95d969b/Cut-to-the-chase-Regulatory-institutions-and-practices.pdf

[55] England Department of Health. (2011). Enabling excellence: Autonomy and accountability for healthcare workers, social workers and social care workers. Cm 8008 Enabling Excellence (publishing.service.gov.uk)

[56] Allison, M J. (2015). *The role of health profession regulation in health services improvement.* Thesis submitted to the Victoria University of Wellington in fulfilment of the requirements for the degree of Doctor of Philosophy thesis.pdf (vuw.ac.nz); MBIE. (2021). *Regulatory impact statement: Occupational regulation of engineers* Regulatory Impact Statement: Occupational regulation of engineers (mbie.govt.nz)

c. **Regulatory system:** Increased regulation can increase costs on the regulatory system through increasing the need for oversight, investigation of complaints, or use of courts.[57]

62. These costs can also impact on consumer choice. Licencing, in particular, may cause lower cost services to be excluded from the market. Depending on who pays, the increase in service costs due to (higher) licensing fees could result in consumers choosing a lower quality service or not consuming the service at all – which could have worse harm outcomes.

Occupational regulation has been applied to indigenous populations and indigenous practices

63. Regulation can impact minority groups through both practice and workforce implications.[58] Addressing indigenous and ethnic social and health inequities requires a system that delivers appropriate, competent, and equitable care.

64. Occupational regulation can have a role in this, for example, some jurisdictions have included cultural competency in health professional licensing legislation, health professional accreditation standards, and pre-service and in-service training programmes.[59]

65. The application of a regulatory regime to cultural practices could also be considered. For instance, consideration of occupational health regulation in Ontario, identified a need to clarify that Aboriginal healers providing traditional healing services were exempt from the regime.[60] This was a key driver in recent amendments to the enrolled nurse scope of practice which did not refer to Te Tiriti o Waitangi, Kawa Whakaruruhau, or cultural safety. The Design Group found "the scope must acknowledge this clearly to ensure enrolled nurses are supported to deliver care that is culturally safe and responsive to the rights and needs of tangata whenua, and does not entrench existing health inequities."[61]

66. Regulation may also have particular workforce impacts on certain populations. A profiling of the Māori health workforce in 2017 found that 71% work within the unregulated workforce, Māori make up 15% of the national unregulated workforce, and this workforce operated in diverse and complex roles that are not restricted to conventional health service settings.[62]

[57] Allison, M J. (2015). *The role of health profession regulation in health services improvement.* Thesis submitted to the Victoria University of Wellington in fulfilment of the requirements for the degree of Doctor of Philosophy thesis.pdf (vuw.ac.nz); MBIE. (2021). *Regulatory impact statement: Occupational regulation of engineers* Regulatory Impact Statement: Occupational regulation of engineers (mbie.govt.nz)

[58] For example, analysis in the US suggests that licensing can ease or hinder access into an occupation for immigrants. Redbird, B., & Escamilla-García, A. A. (2020). Borders within borders: The impact of occupational licensing on immigrant incorporation. *Sociology of Race and Ethnicity, 6*(1), 22-45. https://doi.org/10.1177/2332649219833708https://journals.sagepub.com/doi/full/10.1177/2332649219833708

[59] Curtis, E., Jones, R., Tipene-Leach, D. et al. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition. *International Journal for Equity in Health, 18*(174). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1082-3

[60] Ontario Health Professions Regulatory Advisory Council. (2006). *Regulation of health professions in Ontario: New directions*. Regulation of Health Professions in Ontario: New Directions (hmac.ca)

[61] Nursing Council of New Zealand. (2022). Consultation document, Review of the enrolled nurse scope of practice scope statement. https://www.nursingcouncil.org.nz/Public/Nursing/Scopes_of_practice/Enrolled_nurse/NCNZ/nursing-section/Enrolled_nurse.aspx?hkey=963854c0-246c-4bb1-800c-920a19b022dc.

[62] Sewell, J. (2017). Profiling the Māori health workforce 2017. Wellington, New Zealand: Te Kīwai Rangahau, Te Rau Matatini: https://terauora.com/wp-content/uploads/2022/04/Profiling-of-the-Ma%CC%84ori-Health-Workforce-2017-1.pdf

Step three: Identify the most effective form of government intervention

67. The range and variety of interventions used to address public safety through occupational practice is broad. For occupational regulation, models vary across the following dimensions:

    a. Regulatory form: The broad categories of models are self-regulation, direct statutory regulation, co-regulation, and meta-regulation.[63]

    b. Mechanisms used: Provision of information to consumers, training of practitioners, setting and enforcing standards, specifying services government will purchase, and organisational performance monitoring and management.

    c. Regulatory regime: Disclosure, registration, certification, licencing, or accreditation of provider organisations.

68. The regulatory model used will be a product of the policy problem and policy objectives, and the broader context including legacy regulatory approaches and the overall system. Principles of right touch regulation provide that the intervention should be:

    - focused on and proportionate to the risk of harm, and
    - the minimal level of intervention required to address the problem.

69. The voluntary registration of engineering associates as part of the overall new regime for professional engineers in New Zealand is one that has arisen due to legacy – the existing Engineering Associates Act 1961 – rather than engineering associates reaching particular thresholds for harm to public safety. In relation to the overall system, and a fit for purpose regulatory system, MBIE recently consulted on a review of the current settings for registered architects to determine if the regime is still fit for purpose.[64]

70. Historically, self-regulation has been the primary regulatory model for professions. But with loss of public confidence in self-regulatory regimes,[65] in amongst other reasons, government-imposed interventions have taken a variety of forms.

[63] Australia Professional Standards Council. (2021). *Regulatory structures*. https://www.psc.gov.au/sites/default/files/2021-08/Regulatory%20Structures.pdf ; Australian Government. (2007). *Best practice regulation handbook*. Best Practice Regulation Handbook (regulationbodyofknowledge.org)

[64] MBIE. (2023). Occupational regulation reforms in the building and construction sector | Ministry of Business, Innovation & Employment (mbie.govt.nz)

[65] For example, the Real Estate Agents Act 2008 introduced government regulation of real estate agents following a loss of public confidence in the self-regulatory regime under the old Real Estate Agents Act 1976 and government dissatisfaction at the profession's proposals to improve self-regulation. New Zealand Productivity Commission. (2014). *Regulatory institutions and practices*. https://www.productivity.govt.nz/assets/Documents/d1d7d3ce31/Final-report-Regulatory-institutions-and-practices-v2.pdf

The full range of intervention options should be explored for category 3 workers, including self-regulation and non-regulatory interventions

71. There is a spectrum of forms of regulation. Each has differing characteristics, advantages, and disadvantages including cost-effectiveness, flexibility, responsiveness, accessibility, and level of scrutiny.[66] The full spectrum of regulatory form is evident in occupational regulation in New Zealand and internationally (Table 2).

Table 2: Forms of regulation

Extent of government involvement	**LOW** 				 **HIGH**
Form	**Self-regulation**	**Quasi-regulation**	**Meta-regulation**	**Co-regulation**	**Direct statutory regulation**
Definition	Sector is responsible for regulating their members.	Government influences the sector to comply though pressure to act in a certain way, but rules are not legally binding.	Self-regulation is monitored by an external third party.	Sector develops and administers its own arrangements but government provides legislation to enable it to be enforced.	Government specifies how regulated entities should act.
Mechanisms	• Formulation of rules, standards or codes. • Enforcement of those rules, standards, or codes. • Voluntary certification systems.	• Contracts. • Incentive payments.	• Third party audits. • Mandated incident reporting. • Complaints process to the Ombudsman.	• Sector code is supported by government standards. • Government enforces code compliance.	• Legislation. • Government (usually an agency) undertakes monitoring and investigation. • Compliance is enforced through fines and penalties.
Examples	New Zealand Institute of Legal Executives.	Ministry of Social Development has made funding conditional on Te Kāhui Kāhu accreditation.	Professional Standards Association for Health and Social Care (England).	Medical Council of New Zealand supported by the Health Practitioners Competence Assurance Act 2003.	Social Workers Registration Board. Proposed new regulator for professional engineers.

[66] Australian Government. (2007). *Best practice regulation handbook*. Best Practice Regulation Handbook (regulationbodyofknowledge.org).

Self-regulation

72. Self-regulation is where the sector is responsible for regulating the behaviour of their members by formulating rules, standards or codes, and enforcement. This might involve an industry-level organisation or a professional association acting as a regulator, or may be an individual firm, organisation, or professional undertaking to do the right thing without being influenced or required to.

73. A key advantage of self-regulation is that it enables self-determination for a profession and draws on the expertise of a profession to inform its regulation. This is particularly useful where the practice is complex. Other advantages include flexibility (no need to change the law) and reduced cost. A key disadvantage of self-regulation is the potential for perverse incentives, with the industry using regulation to advance its own interests, to the potential detriment of consumers and others.[67] Criticism of self-regulation argues that it can be used to restrict entry to a profession, increasing renumeration and establishment of a monopoly.[68] Studies in the US and UK have shown it can significantly increase costs for consumers.[69]

74. **Example:** The New Zealand Institute of Legal Executives (NZILE) is the professional body which requires legal executives to achieve and maintain high standards of practice in order to be a member. "Registered Legal Executive" is the status for NZILE affiliates, associates, and fellows. There is no statutory protection of the title "Legal Executive". Registration differentiates qualified and experienced legal executives from non-members, whose firms call their staff legal executives, but who may or may not be qualified or even doing the work of a legal executive.

Quasi-regulation

75. Quasi-regulation is where the government influences the sector to comply though pressure to act in a certain way but does not create legally binding rules. This might include making compliance a pre-condition of involvement in government contracts and benefits. Mechanisms to encourage adherence include incentive payments, governance by contracting, and performance league tables or public rating.[70]

    a. **Information publication:** The Care Quality Commission in the UK provides public ratings based on accreditation (Outstanding, Good, Requires improvement, or Inadequate) which enables consumers to make informed choices, and incentivises improvement in providers.[71]

    b. **Government endorsement of codes of practice, standards, or guidance.**

[67] UK Department of Business, Energy and Industrial Strategy. (2019). Designing self- and co-regulation initiatives: Evidence on best practices: A literature review (BEIS Research Paper 2019/025). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/840564/designing-self-co-regulation-initiatives.pdf

[68] Svorny, S. (2000). Licensing, market entry regulation, in *Market entry regulation, Encyclopedia of Law & Economics, Vol. III, The regulation of contracts*, Bouckaert, B & De Geest, G (eds), pp. 296-328 C:\001PDFversieENCY vol3\5120booknw.PDF (researchgate.net)

[69] Allison, M J. (2015). *The role of health profession regulation in health services improvement.* Thesis submitted to the Victoria University of Wellington in fulfilment of the requirements for the degree of Doctor of Philosophy thesis.pdf (vuw.ac.nz)

[70] Schweppenstedde D, Hinrichs S, Ogbu U, Schneider EC, Kringos DS, Klazinga NS, Healy J, Vuorenkoski L, Busse R, Guerin B, Pitchforth E, Nolte E. (2014). Regulating quality and safety of health and social care: International experiences. *Rand Health Quarterly*, 4(1). Regulating Quality and Safety of Health and Social Care – PMC (nih.gov)

[71] The New Zealand Commerce Commission has recently applied this approach to telecommunication services.

c. **Influence through contracting:** The Cabinet Office has identified the ability of the government to use its influence as a major employer and purchaser of services to set standards it requires practitioners to meet.[72] For instance, the government can choose to purchase only those services provided by practitioners who meet pre-defined standards, such as having particular qualifications (for example, reimbursement of treatment costs through ACC is made only to providers with particular qualifications). The Productivity Commission has identified "contracting for outcomes" as a measure to improve the quality of social services.[73]

76. Advantages are greater flexibility and responsiveness, lower costs, and greater collaboration with the wider sector. Disadvantages are a reduced ability to influence outcomes given requirements are not mandatory.

77. **Example:** Te Kāhui Kāhu provides assurance that social service providers can deliver quality services. A range of agencies have requirements for service providers to have achieved accreditation to receive funding, or to be able to be contracted. Te Kāhui Kāhu provides accreditation assessments, and assesses organisations regularly to ensure they continue to meet the standards.

78. **Example:** Accreditation for counselling in health settings is a collaboration between Te Rōpū Kaiwhiriwhiri o Aotearoa New Zealand Association of Counsellors (NZAC) and Te Whatu Ora that started in August 2022. While the counselling profession is self-regulated, full members of NZAC can be accredited and apply for health contracts or employment funded by Te Whatu Ora. Accreditation requires a degree, registration with the NZAC, practicing certificate, police vetting, and CPD.[74]

79. Previously only practitioners registered under the Health Practitioner Competence Assurance Act (HPCA Act) could deliver clinical services in the public health system. The benefit for Te Whatu Ora is the increased in the mental health workforce who are available to support more people who are experiencing mental health issues and ensure greater accessibility to counselling services.

Meta-regulation

80. Meta-regulation describes an approach by which the conduct of self-regulation is monitored by an external third party. Meta-regulators typically use accreditation schemes to assess the ability of the self-regulator (a sector organisation or service provider) to provide a certain quality of service. There may be sanctions and incentives that help ensure adherence. Examples include clinical audits conducted externally, mandated incident reporting systems, and consumer complaints to the Ombudsmen.[75]

[72] Cabinet Office. (1999). *Policy framework for occupational regulation*. Cabinet Office Circular, CO (99) 6. Cabinet Office Circular CO (99) 6: Policy Framework for Occupational Regulation - 8 June 1999 (dpmc.govt.nz)

[73] New Zealand Productivity Commission (2015). *More effective social services*. More effective social services (productivity.govt.nz)

[74] Te Whatu Ora & NZAC. (2022). *Statement of practice for counselling in health settings*. Statement-of-Practice-for-Counselling-in-Health-Settings-2022.pdf (nzac.org.nz)

[75] Schweppenstedde D, Hinrichs S, Ogbu U, Schneider EC, Kringos DS, Klazinga NS, Healy J, Vuorenkoski L, Busse R, Guerin B, Pitchforth E, Nolte E. (2014). Regulating quality and safety of health and social care: International experiences. *Rand Health Quarterly*, 4(1). Regulating Quality and Safety of Health and Social Care - PMC (nih.gov)

81. Advantages and disadvantages are similar to those for co-regulation.

82. **Example**: An example of a meta-regulator in New Zealand includes the Health and Disability Commissioner. In the UK, the Professional Standards Authority for Health and Social Care oversees 10 regulators including Social Work England and the Health and Care Professions Council. This seeks to protect the public by improving the regulation and registration of people who work in health and social care by:

    - reviewing the work of the regulators of health and care professionals
    - accrediting organisations that register practitioners in unregulated occupations,
    - giving policy advice to Ministers and others, and
    - encouraging research to improve regulation.

Co-regulation

83. Co-regulation is where the industry develops and administers its own arrangements but the government provides legislative backing to enable arrangements to be enforced. This might occur where the government supports compliance with a sector code or delegates regulatory roles to the sector. This approach is used in New Zealand's health sector, as well as in Ontario and the UK.

84. Advantages are lower government costs and use of industry expertise, better responsiveness, and credibility. Disadvantages are complexity, inability to change, potential for conflicting incentives, and increased costs of regulation and compliance.

85. **Example:** The model under the Health Practitioner Competence Assurance Act 2003 is an example of co-regulation. This regime provides for title protection and the role of regulatory authorities in regulating to achieve public safety. These authorities are comprised of a majority of members who are health practitioners, appointed by the Minister of Health.

Direct statutory regulation

86. Explicit or direct statutory regulation is where the government:

    - specifies how regulated entities should act
    - undertakes monitoring and investigation, and
    - enforces compliance (through fines and penalties).

87. Mechanisms to secure standard adherence include criminal or civil penalties, licence revocation, or suspension.

88. Advantages of this approach are more certainty, full coverage, and greater effectiveness given the availability of legal sanctions. Disadvantages are inflexibility, inability to change, complexity, and increased costs of regulation and compliance.

89. **Example:** The proposed occupational regulatory regime for professional engineers is an example of direct statutory regulation.[76] The regime requires the registration and licencing of all engineers. A new Board would oversee the regime by disciplining engineers, hearing compliance, and undertaking enforcement. Legislation would include a new criminal offence for providing engineering services without being registered or practicing without a licence where one is required.

Form should follow function

90. The most effective regulatory form will depend on the context, what policy objectives wish to be achieved, and the problem definition. A variety of factors are relevant to choosing the best approach. At a high level, these factors include the severity of the problem, the extent of risk, the nature of the industry or sector, the need for flexibility or certainty of regulatory arrangements, and the availability of resources.

    a. **Self-regulation** is typically appropriate where risks are easily managed or of low impact; highly technical and complex issues are involved that require sector expertise; the problem can be fixed by the market itself (that is, there is an incentive to comply); and there is no public interest or concern.[77]

    b. **Quasi and co-regulation** should be considered where there is a public interest in government involvement in regulatory arrangements; the issue is unlikely to be addressed by self-regulation; there are advantages to flexible, sector specific and less formal solutions (both cost and in bespoke application); and there are viable sector associations or bodies that have the resources to ensure compliance.

    c. **Direct statutory regulation** should be considered where the problem is high-risk and of high impact; the government requires certainty provided by legal enforcement; universal application is required; there are systematic compliance problems; and existing sector bodies are unable to regulate.

Other mechanisms may be suited to address any risk that may be identified for category 3 workers

91. In relation to step three of the occupational regulation policy framework, the Cabinet Office circular reminds us to consider the nature of problem posed by the occupation, and whether it would be solved by other mechanisms,[78] for example by:

    - the provision of information to consumers, including information about what to do if you have a concern
    - training practitioners

[76] MBIE. (2021). *Regulatory impact statement: Occupational regulation of engineers* Regulatory Impact Statement: Occupational regulation of engineers (mbie.govt.nz)

[77] Compliance Common Capability Programme. (2011). *Achieving compliance: A guide for compliance agencies in New Zealand*. https://apo.org.au/sites/default/files/resource-files/2011-07/apo-nid303500.pdf

[78] Cabinet Office. (1999). *Policy framework for occupational regulation*. Cabinet Office Circular, CO (99) 6. Cabinet Office Circular CO (99) 6: Policy Framework for Occupational Regulation - 8 June 1999 (dpmc.govt.nz)

- setting and enforcing standards
- specifying services government will purchase, including using available contracting levers, or
- organisational performance monitoring and management.

Provide consumers with assurance of standards

92. This assurance process seeks to provide consumers with an indication and form of guarantee as to the quality of the service provided.[79] In economic terms, this decreases the cost to consumers of measuring the quality of services and can avoid market failure due to asymmetric information between producers and consumers.

93. For the category 3 workforce, this might mean a campaign to users to make sure they are aware of the expected standards of practice. Standards may require the workforce, or particular high-risk work, to be supervised by a registered social worker. However, this approach may not be practical given current difficulties with the quantity and quality of supervision for new and emerging social workers.

94. In Wales, both social care workers and social workers are required to be registered[80], but within the 'information for public' section on their website it states that there is a Code of Professional Practice for Social Care which sets out the rules or standards which care professionals must work to, to help keep the public safe and well.[81]

Advocacy

95. Advocacy can also play a role in improving safety outcomes through increasing service quality and educating consumers on their rights and avenues of redress for poor practice. For the health sector in New Zealand, this role is played by the Health and Disability Commission, which has been deemed a successful model in contributing to patient safety and the health of consumers.[82]

96. There does not appear to be an analogous function for the social sector. Potential interventions could involve introducing an advocacy function or a process for complaints that applies to all Category 3 workers if users have a concern about the way they have been treated.[83]

[79] UK Commission for Employment and Skills. (2011). *A review of occupational regulation and its impact* (Evidence Report 40). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/306359/ER40_Occupational_regulation_impact_-_Oct_2011.pdf

[80] Social care workers include adult care home managers; domiciliary care managers and domiciliary care workers; residential childcare managers and residential childcare workers; residential family centre managers; social workers and social work students; adoption service managers; adult care home workers; adult placement managers; advocacy managers working with children; fostering service managers; residential family centre workers.

[81] Social Care Wales. (2023). Codes of Professional Practice and guidance. Codes of Practice and guidance | Social Care Wales

[82] Drage, J. (2013). New Zealand's National Health and Disability Advocacy Service: A successful model of advocacy. *Health and Human Rights Journal, 14*(1), https://www.hhrjournal.org/2013/08/new-zealands-national-health-and-disability-advocacy-service-a-successful-model-of-advocacy/

[83] The effectiveness of this would depend on the ability and desirability of users to complain and be supported, given the skills, time and energy that would be required. Creation of an analogous function for the social sector would also depend on whether existing avenues are available.

Training of practitioners

97. Education and training can improve the capability of practitioners and can help mitigate particular risks.

    a. **Compulsory education and training:** Regulators typically have a key role in setting standards on the education and training required to obtain certification or a licence. This can be both pre- and post-regulation (CPD), and can range from requiring a degree to completion of a short course (for instance, to obtain a manager's certificate to sell alcohol, completion of a short course and interview is required). This can also be incentivised – primary teachers are offered higher salaries for higher qualifications.

    b. **Provision of education and training:** The UK Government has recently announced funding to train 500 new youth workers so young people will get better support and service.[84] The Australian Association of Social Workers offers training and online courses to upskill its workforce.

    c. **Cultural training and competency:** The Ontario College of Social Workers and Social Service Workers has committed to the Trust and Reconciliation Commission of Canada, which ensures that registrants are well-informed about the issues faced by Indigenous peoples. Similarly, the Australian Association of Social Workers provides practice information on aboriginal practice.[85]

98. The survey of category 3 workers found that there were a variety of qualifications held by practitioners. While the survey found half were qualified at the bachelor's degree level and some had social work qualifications, it was not representative and further research is required to validate this.

Setting and enforcing of standards

99. Standards of practice, conduct, ethics, and competence are often used to manage safety in practice. They are used in all the case studies in Appendix 1. These may be voluntary and include non-binding guidance or may be conditional as part of the regulatory regime. These typically have the aim of providing benefits to the consumer and/or protection from harm that could be caused by members of their occupation.

100. Standards mean that low quality workers are forced out (either by not meeting the barriers to entry or removal from practice), while others need to increase their human capital through education and training. Meeting these standards is a requirement for licencing and an incentive for certification (given it provides a right to title).

[84] Department for Culture, Media and Sport. (2023, 27 September). Government funding to train 500 new youth workers. https://www.gov.uk/government/news/government-funding-to-train-500-new-youth-workers

[85] AASW. (2023). Culturally responsive and inclusive practice in Australia. https://ao.aasw.asn.au/practitioner-resources/culturally-responsive-and-inclusive-practice-in-australia

101. Standards typically address both competence and fitness to practice. Note that these outcomes are not guaranteed; occupational regulation has been criticised for not actually having an impact on quality improvement.[86]

102. Enforcement to ensure compliance with standards is an important part of any regulatory system. Of particular relevance to worker regulation is the need to exclude workers from practice where serious breaches have occurred. There is limited ability to exclude these workers from practice where they are not regulated. These issues are likely to apply to the category 3 workforce, including workers simply moving jobs but staying in the same sector where serious issues have been identified. Holding practitioners to account was a key driver in the proposed occupational regulation of engineers.[87]

103. Enforcement may involve proceedings that remove the right of the worker to use a certain title or practice in a certain scope. In the health sector, the Health Practitioners Disciplinary Tribunal undertakes this role. For registered social workers, complaints are first investigated by the SWRB Professional Conduct Committee. The most serious cases may be referred to the Social Workers Complaints and Disciplinary Tribunal, which is independent of the SWRB.

Specifying services that the government will purchase

104. As mentioned previously, Te Kāhui Kāhu already provides assurance that social service providers can deliver quality services. The regulation of category 3 workers should consider to what extent Te Kāhui Kāhu already provides monitoring and oversight of social service providers with respect to category 3 workers sufficient to address public safety, or whether it needs to be strengthened. The level of assurance provided by Te Kāhui Kāhu is focused on the overall quality, system, and processes of an organisation. There is currently little assessment on workforce practices.

105. For other professions and jurisdictions, this role is undertaken by the regulator of the worker or regulator of employers. Regulators typically have oversight functions that include checks on practice and character and investigations into issues. For example, the new engineering regulator would also have the power to audit a licensed engineer's work, both periodically or as part of an investigation into an engineer's conduct. The CQC in the UK undertakes inspections on-site and is supported by the provision of pre-recruitment checks on workers by the Disclosure and Barring Service.

Organisational performance monitoring and management

106. Organisational performance monitoring and management has a critical role in addressing safety. This can be imposed on the provider (the Health and Social Care Act 2008 (UK) requires service providers to have oversight of employees) or self-driven. This form of oversight is particularly

[86] UK Commission for Employment and Skills. (2011). *A review of occupational regulation and its impact* (Evidence Report 40). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/306359/ER40_Occupational_regulation_impact_-_Oct_2011.pdf

[87] MBIE. (2019). Building system legislative reform: occupational regulation. Occupational regulation summary (mbie.govt.nz); MBIE. (2021). *Regulatory impact statement: Occupational regulation of engineers* https://www.mbie.govt.nz/dmsdocument/19611-establishing-a-new-occupational-regulatory-regime-for-professional-engineers-proactiverelease-pdf

important for unregulated workers, where "the emphasis should be on employers of unregulated workers to take responsibility for the quality of services provided."[88]

107. This is consistent with other reviews of unregulated health care professionals, which emphasise the importance of training, supervision, and staffing for patient safety and quality of care.[89] Other examples of typical organisational mechanisms for ensuring the quality of the service, including clinical governance, voluntary accreditation, peer review, protocols, performance indicators/targets, and benchmarking.[90]

108. A review of Ontario's health workforce regulatory system also emphasised the importance of this, recommending a "transition from a reliance on controlled acts and defined scopes of practice towards competency-based oversight" and to "integrate employers and healthcare organisations into workforce oversight." [91]

Target the aspect that gives rise to public safety risks

109. Cabinet Office also specifies that if only a specific aspect of the practice of an occupation poses a threat to consumers or third parties, the best solution is to target that aspect rather than legislate to regulate the occupation.

110. It is a tradition of many professions that professional supervision occurs between two people from the same discipline or profession.[92] There is a role for both employers and regulators in supporting this type of supervision by providing clear guidance on responsibilities, policies, processes for evaluation, supervision monitoring, and support.[93] The New Zealand Nurses Organisation has provided guidance on how to delegate tasks to unregulated heath care workers.[94] Peer supervision is particularly important for volunteers.[95]

111. Note that category 3 workers are currently defined as those who are under the supervision of registered social workers although the extent of this supervision in practice is not yet clear. The survey identified supervision as a key tool for ensuring safe practice. Existing, or new, mechanisms that specify or require this supervision could be considered.

88 England Department of Health. (2011). Enabling excellence: Autonomy and accountability for healthcare workers, social workers and social care workers https://assets.publishing.service.gov.uk/media/5a7c104240f0b63f7572b1e1/dh_124374.pdf; Duffield, C., Twigg. D., Pugh, J.D., Evans, G., Dimitrelis, S., & Roche, M.A. (2014). The use of unregulated staff: Time for regulation? *Policy, Politics, & Nursing Practice, 15*(1-2), 41-48. AIN_Regulation_Final_PPNP (uts.edu.au)

89 Afzal, A., Heckman, GA, Boscart, VM, & Sanyal, C. (2018. The role of unregulated care providers in Canada—A scoping review. International Journal of Older People Nursing, The role of unregulated care providers in Canada—A scoping review (researchgate.net)

90 Schweppenstedde D, Hinrichs S, Ogbu U, Schneider EC, Kringos DS, Klazinga NS, Healy J, Vuorenkoski L, Busse R, Guerin B, Pitchforth E, Nolte E. (2014). Regulating quality and safety of health and social care: International experiences. *Rand Health Quarterly, 4*(1). Regulating Quality and Safety of Health and Social Care - PMC (nih.gov)

91 McMaster Health Forum. (2019). *Examining the efficiency and effectiveness of Ontario's health workforce regulatory system*. Examining the Efficiency and Effectiveness of Ontario's Health Workforce Regulatory System (mcmasterforum.org)

92 Davys, A. (2017). Interprofessional supervision: A matter of difference. *Aotearoa New Zealand Social Work, 29*(3), 79-94.

93 Saari, M., Xiao, S., Rowe, A., Patterson, E., Killackey, T., Raffaghello, J., & Tourangeau, A E. (2018). The role of unregulated care providers in home care: A scoping review. *Journal of Nursing Management, 26*(7), 782-794.The role of unregulated care providers in home care: A scoping review - Saari - 2018 - Journal of Nursing Management - Wiley Online Library

94 New Zealand Nurses Organisation. (2011). Unregulated health care workers (Position statement). LinkClick.aspx (nzno.org.nz)

95 Rushton, J. (2015). Volunteer peer supervision: In an ever-changing social service environment. *Aotearoa New Zealand Social Work, 27*(3), 68–77 Volunteer peer supervision: In an ever-changing social service environment | Aotearoa New Zealand Social Work (anzswjournal.nz)

Step four: If legislation is required, what type of regulatory regime is needed?

112. There are four types of occupational regulation regimes:[96] disclosure, registration, licencing, and certification.[97] Additionally, accreditation regimes can indirectly impose requirements on practitioners though an organisation.

Disclosure

113. Disclosure is where providers of a service are required to provide specified information to prospective users of the service.[98] It can be used to make consumers aware that some services provided by occupations, if performed incompetently or dishonestly, could pose a risk. Information may also be provided to assist consumers to choose competent practitioners and be aware of the remedies available to them through consumer legislation.

114. This approach is used in regulation of financial advisors: "Disclosure is an important tool for addressing the information asymmetry inherent in financial advice. Disclosure ensures that consumers have sufficient information about the person providing them with financial advice, before engaging their services."[99] Additionally, the UK's Care Quality Commission rating system is a form of disclosure regime.

Registration

115. Registration is where practitioners are listed on a public register. This can be a requirement to practice and is typically associated with certification and licencing (for example, registration may be dependent on certification). Registration on its own does not convey any suggestion of competence or quality of service, so it is usually used where the threat to public health, safety, or welfare is minimal. It is generally used for administrative purposes to provide a means of identifying and contacting practitioners.

116. In Wales and Ontario, Canada, social care workers and social service workers are required to be registered. In New Zealand, the proposed scheme for engineers would require all practitioners to be on the register. The register is considered to be "an effective tool for ensuring all members of a profession are suitably qualified and practitioners can be held to account for poor conduct. The register also allows consumers to know whether a person is registered or licensed, and their

[96] Cabinet Office. (1999). *Policy framework for occupational regulation*. Cabinet Office Circular, CO (99) 6. Cabinet Office Circular CO (99) 6: Policy Framework for Occupational Regulation - 8 June 1999 (dpmc.govt.nz)

[97] Confusingly, these terms are often used interchangeably, that is, what is actually a licencing scheme will be referred to as a registration.

[98] Cabinet Office. (1999). *Policy framework for occupational regulation*. Cabinet Office Circular, CO (99) 6 Cabinet Office Circular CO (99) 6: Policy Framework for Occupational Regulation - 8 June 1999 (dpmc.govt.nz)

[99] MBIE. (2016). *Review of the operation of the Financial Advisers Act 2008 and the Financial Service Providers (Registration and Dispute Resolution) Act 2008* https://www.mbie.govt.nz/dmsdocument/944-final-report-review-of-the-operation-of-the-fa-and-fsp-acts-pdf

registration or licence history, including whether they have been disciplined in the past three years."[100]

Certification of practitioners

117. Certification is where an individual is deemed to have met certain requirements. While certification does not provide an exclusive right to practice it usually provides a right to title. This provides the certified practitioner with a competitive advantage over non-certified practitioners. Certification is usually used to show the practitioner has meet a certain level of education and training, adheres to codes of conduct and practice, and is subject to disciplinary processes that can ultimately remove the certification and right to title. This may also include a requirement to practice within a defined scope of practice and practicing outside this scope could result in disciplinary action. This provides a level of assurance to consumers that the certificated practitioner will deliver a service of a certain standard.

118. Certification regimes vary in the intensiveness of requirements. Examples are:

    a. Australian Association of Social Workers provides credentials in various specialisations which generally just require a certain level of experience in a certain area (as well as being a member).

    b. To manage a licenced premises under the Sale and Supply of Alcohol Act 2012 a Manager's Certificate is required. To obtain a certificate, applicants must hold a Licence Controller Qualification which is two short courses that demonstrate understanding of the Act and responsibility requirements. Applicants are also checked by the District Licencing Committee on their suitability, convictions, experience, training, qualifications, and police report.[101]

    c. Social service workers in Ontario must hold an approved diploma (including field placement), engage in continuing competence, and meet standards of practice and ethics.

    d. Legal executives are required to hold a diploma, be employed as a legal executive, work under the supervision of a lawyer, do 70% of legal executive work, have a certain level of experience, and undertake CPD.

Licencing

119. Licensing is where it is unlawful to carry out a specified range of work without first having obtained a licence. It involves using legislation to grant an exclusive right to licenced practitioners to do the tasks or work. Similar to certification, the licence usually certifies the practitioner meets certain standards, that they are competent, and fit to practice.

[100] MBIE. (2022). Establishing a new occupational regulatory regime for professional engineers. https://www.mbie.govt.nz/dmsdocument/19611-establishing-a-new-occupational-regulatory-regime-for-professional-engineers-proactiverelease-pdf

[101] Alcohol.org.nz. Managers of licenced premises: https://resources.alcohol.org.nz/alcohol-management-laws/licensing-local-policies/managers-of-licensed-premises

120. Licencing of workers is the least flexible form of occupational regulation, as those not meeting the entry requirements are unable to practice. It minimises the risk to the public from unskilled practitioners by requiring all who practice to meet particular standards on entry.

121. Licencing can apply to tasks or workers:

    a. **Licensing tasks**: This involves prohibiting anyone except licenced workers from performing certain tasks. An example is that only registered practitioners, dentists, and veterinarians may prescribe drugs. Regulation of this kind is generally used where poor performance of a particular task is likely to impose severe harm on consumers.

    b. **Licensing a profession**: This regime explicitly prohibits all but licensed persons from practicing a profession, as defined by a scope of practice. While licencing tasks is a more focused intervention, licencing a profession is sometimes required where it is impossible to discern particular acts that create risk of harm from the practice of the professions.[102]

122. The proposed regime for engineers utilises licencing but only for services in high risk engineering practice fields, with other engineers needing to be registered and certified but not licenced. This was proposed because, "while all aspects of engineering have potential risk, some engineering practice fields pose a higher risk to health and safety than others and warrant additional checks on an engineer's competence and experience".[103]

123. **Negative licencing** is where "individuals are generally entitled to practise but can be prohibited from practising if they have committed some form of offence deemed serious enough to warrant exclusion from the industry." [104] This is usually focused on practice where certain standards of conduct are important. An example is Oranga Tamariki using the police vetting service for people, such as caregiver or adoptive parent applicants, mentors, or volunteers to help them assess their suitability to care for, or have contact with, children.

Certification/accreditation of providers[105]

124. Accreditation of service providers is widely used as a tool for improving or regulating quality and safety in social care providers.[106] "In various industries, accreditation is recognised as a symbol of quality, indicating that the organisation meets certain performance standards, and provides an

[102] Ontario Health Professions Regulatory Advisory Council. (2006). *Regulation of health professions in Ontario: New directions*. Regulation of Health Professions in Ontario: New Directions (hmac.ca)

[103] MBIE. (2022). Establishing a new occupational regulatory regime for professional engineers. https://www.mbie.govt.nz/dmsdocument/19611-establishing-a-new-occupational-regulatory-regime-for-professional-engineers-proactiverelease-pdf

[104] Fells, A. (2001). *Regulation, competition, and the professions*. Industry Economics Conference – Australian Competition and Consumer Commission. https://www.accc.gov.au/system/files/Fels_Industry_Economics_14_7_01%5B1%5D.pdf

[105] While technically certification and accreditation have different meanings they are often used interchangeably (e.g. what is technically a certification scheme is called an accreditation scheme and vice versa). Certification is an audit of whether an organisation, product or individual, conforms to the criteria laid out in a recognised standard or scheme. Accreditation is a rung further up the ladder, performing an oversight role that underpins the quality, impartiality and competence of the certification process: https://www.ukas.com/accreditation/about/accreditation-vs-certification/. We have used these terms interchangeably in this report to avoid confusion.

[106] Cochrane D. (2014). Securing patient safety through quality assurance in a mixed economy of healthcare: The role of accreditation. *Clinical Risk, 20*(4):82-89. https://journals.sagepub.com/doi/10.1177/1356262214542520

opportunity for that organisation to evaluate their operation against national or international standards.[107]

125. Examples are Te Kāhui Kāhu which undertakes social service provider accreditation in New Zealand. When undertaking an accreditation assessment, Te Kāhui Kāhu looks at how an organisation conducts its finances and its operating principles in regard to staff, governance, programmes, and services and meeting the needs of clients experiencing vulnerability. Another example is the Care Quality Commission (CQC) which regulates health and social care services in the UK. The National Youth Agency in the UK has developed and implemented a Quality Mark as a tool to support organisations assessing the quality and impact of their work with young people.[108]

[107] Kis, V. (2005). Quality assurance in tertiary education: Current practices in OECD countries and a literature review on potential effects. Tertiary Review: A contribution to the OECD thematic review of tertiary education, 14(9), 1-47.

[108] National Youth Agency. (2022). *Quality Mark framework: Improving youth work practice, recognising excellence* 5.1.2-NYA-QM-Framework-Only-FINAL-MASTER.pdf (amazonaws.com)

Findings and implications

This section outlines the findings of the analysis and summarises how public safety could be addressed in category 3 workforce.

126. Treasury guidance sets out government expectations for good regulatory practice and the Cabinet Office circular from 1999 provides a framework for the key considerations for any regulatory intervention. These are a clear problem identification and objectives, and an understanding of the efficiency, effectiveness, benefits, and costs of the full range of intervention options that could solve the problem.

127. If significant harm is likely and existing means of protection are insufficient, then there is a strong case for intervention. Interventions should be focused on policy outcomes and be proportionate to the risk.

Further exploration is required as to whether the policy problem in relation to category 3 workers is sufficiently articulated or evidenced to warrant regulation

128. The process and criteria for health professions requires consideration before occupational regulation can be applied to this workforce. Firstly, we need to be satisfied that the services pose a risk of harm to the public, or that it is otherwise in the public's interest that the service be regulated.

129. The size and scale of public safety concerns are yet to be confirmed. However, it is recognised that category 3 workers are often working with populations experiencing vulnerability. Risks that can arise from registered social work practice may also apply to the practices of the category 3 workforce, given they are often undertaking similar work. The policy work undertaken for registering social workers identified a "small but significant risk of serious harm".[109] There is some anecdotal evidence of harm in relation to category 3 workers. Further work on the nature and scale of the risk posed by the practice of category 3 workers, and the evidence for this, is required before further design work can be undertaken on regulatory tools.

130. Additionally, further work on the definition of category 3 workers may be required. The work undertaken to date suggests that the qualifications for category 3 workers are varied, and the competencies and standards may also vary. Category 3 workers may not be a cohesive enough

[109] The Regulatory Impact Statement for Legislative changes to increase the professionalism of the social work workforce (2017) provides, "There is a small but significant risk of serious harm to clients from incompetent social work because of the nature and circumstances of the client group and the range of interventions delivered by social workers. Incompetent practice can cause immediate harm and the impact may also be long lasting. That is why skilled, well-trained professionals are required". https://www.msd.govt.nz/documents/about-msd-and-our-work/publications-resources/regulatory-impact-statements/swra-ris.pdf

profession suitable for regulation, or be the appropriate way of defining the profession given the risks identified and the nature of the profession.

131. This also raises the question of wider workforce accountabilities. For example, those who are not supervised, but are undertaking social work 80% of their time are not included. However, they may be operating in a way that is consistent with the intent of being a regulated profession.

Whether the costs related to regulation for category 3 workers outweigh the potential benefits may need to be quantified

132. In the health and social care sector, regulation can stifle innovation, reinforce siloed working, be a barrier to multidisciplinary teams, increase complexity, and hinder workforce optimisation. Costs to government and costs to service users are of particular concern in the social services sector given labour supply challenges (particularly high workforce demand and high rates of worker burnout), and for the category 3 workforce, many who are likely to be low paid. Most occupational regulations impose high costs on the system, government, and the public.

Existing mechanisms could be assessed to the extent they already address the risk to public safety

133. There are a variety of options to ensure any interventions reflect the context and address the problem in an effective, efficient, and proportionate way. New Zealand and international jurisdictions draw on a wide range of approaches to address public safety in the workforce. These approaches vary by form (direct regulation, co-regulation, meta-regulation, and quasi-regulation), nature of the requirement (registration, certification, licencing, and certification/accreditation of organisations), and the interventions used (provision of information to consumers, training of practitioners, setting and enforcing standards, specifying services government will purchase, and organisational performance monitoring and management).

134. The models and examples identified present a broad set of options for addressing public safety in occupational practice (should an intervention be deemed necessary).

135. There appear to be a number of existing mechanisms that could be further investigated to manage public safety in relation to category 3 workers. These include:

- Te Kāhui Kāhu, and whether requirements are sufficient to provide oversight and monitoring of the practices of category 3 workers. This might examine the supervision service providers have in place as well as training and professional development they provide.
- Requirements for registered social workers, and whether supervision of category 3 workers should be, or could be, specified in existing legislation or regulation.
- How contracting levers could be used to influence public safety (for example, specifying the qualification and supervision accountabilities of who is expected to fill certain roles, funding of practice lead positions for supervision, and incentivising using qualified or certified/registered workers).

The most appropriate interventions for category 3 workers will depend on the nature of the risk of harm, and the costs and benefits of interventions

136. Ultimately, the most appropriate intervention will depend on a range of factors and considerations. As discussed, Cabinet Office guidance provides that interventions should be informed by consideration of the risk of harm, the options, and their costs and benefits. This report seeks to support this analysis and the application of this framework to category 3 workers by outlining how risks of harm are addressed in analogous occupations. It identifies key considerations when identifying occupational interventions and regulation in the health and social care sectors, and the various approaches that could be taken to address the risk of harm. A summary of how the range of interventions identified could apply to category 3 workers is outlined in Table 3.

Table 3: Potential interventions for category 3 workers, depending on level of risk of harm

		LOWER RISK OF HARM LOWER INTENSITY OF INTERVENTION		HIGHER RISK OF HARM HIGHER INTENSITY OF INTERVENTION	
Form	**Self-regulation**	Establish a professional association body for category 3 workers	New Zealand Institute of Legal Executives		
	Quasi-regulation	Influence outcomes through conditions on funding, such as accreditation	Ministry of Social Development requiring Te Kāhui Kāhu accreditation for funding or contract	Endorse a code of practice or publish ratings of providers	Care Quality Commission (England)
	Meta-regulation	Establish a new self-regulator and have oversight of it	Professional Standards Authority (England)	Set service standards for providers and monitor this	Care Quality Commission (England)
	Co-regulation	Support outcomes through other system interventions, like providing avenues for complaint and remedy	Health and Disability Commission	Establish a new body for category 3 workers supported by legislation for enforcement of a code of practice	Medical Council of New Zealand ; Social Workers Registration Board Professional Conduct Committee, and referral to independent Social Workers Disciplinary Tribunal
	Direct regulation			Provide the SWRB with the ability to regulate	SWRB regulation of registered social workers
Regime	**Register**	Use a mandatory or non-mandatory register	Proposed voluntary Engineering Associate register	Require registration	Proposed professional engineers register; Social Care Wales; Ontario College of Social Workers and Social Service Workers
	Accreditation			Accredit service providers (organisations)	Te Kāhui Kāhu and Care Quality Commission (England)
	Certification	Introduce a light-touch certification scheme	Legal Executives or Bar Managers Certificate	Require certification	Managers certificate, social service workers
	Negative licencing	Prohibit workers from practice if they have committed some form of offence deemed serious enough to warrant exclusion from the industry	Oranga Tamariki vetting of workers; Disclosure and Barring Service (UK)	Licence Category 3 workers	Licenced engineers
Interventions	**Advocacy**	Support consumer rights through advocacy	Health and Disability Commissioner		
	Education and training	Offer and fund voluntary trainings	Australian Association of Social Workers voluntary certification courses	Set standards for minimum education and training	Social service workers (Ontario), enrolled nurses
	Management and funding	Explore how other interventions or factors influence outcomes eg, overall level of resourcing or service models. Employers check qualifications, convictions; use job descriptions; management of competency. Ensure management and funding is at a level that achieves risk outcomes		NGOs, social services providers. Te Kāhui Kāhu accreditation checks whether the organisation can financially support itself; Care Quality Commission (England) which checks sufficient staffing levels and support.	
	Oversight and supervision	Ensure providers and/or social workers practice oversight and supervision of category 3 workers	NZ Nurses Organisation Guidance	Require providers to ensure appropriate oversight and conduct checks and audits	Care Quality Commission (England) checks employers are ensuring sufficient supervision of employees.
	Standards, guidance and expectations	Provided guidance expectations to service providers and registered social workers on supervision, and use voluntary codes of conduct	Guidance to nurses for supervising unregulated healthcare workers (NZNO)	Set practice standards	Social care workers (Wales), social service workers (Ontario), enrolled nurses, engineers, legal executives

Appendix 1: Case studies

International

Social care providers, England

Regulation	**Regulation of care providers, including social care provided by local authorities and care provided by the National Health Service (NHS).**
Regulator	Care Quality Commission (CQC)
Legislation	Health and Social Care Act 2008 – legal framework for the organisation and delivery of social care.
What is regulated?	Designated regulated activities. • Any organisation carrying out any of these activities is required to register with the CQC, and to have a registered manager for each regulated activity it undertakes. • Regulated activities include the provision of personal care and the provision of residential accommodation together with nursing or personal care.
Standards and requirements	Regulations under the 2008 Act create a wide range of legal duties on those carrying out "regulated activities". The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended) are pivotal, and contain, a series of 'fundamental standards' for care. These include three which relate specifically to workers: • Regulation 12(2)(c), which is about safeguarding. Persons providing care or treatment to service-users have the qualifications, competence, skills, and experience to do so safely. • Regulation 18, which relates to staffing. Sufficient numbers of suitably qualified, competent, skilled, and experienced persons must be deployed. Employers must ensure that employees receive adequate training, support, professional development, supervision, and appraisal to carry out their role. • Regulation 19, which imposes an obligation to ensure that 'fit and proper' persons are employed to provide care. This means that the person must be of 'good character', have the qualifications, competence, skills, and experience necessary for them to perform their role, and be physically and mentally capable of carrying out tasks intrinsic to the role (after reasonable adjustments are made if relevant).
Education, training, and CPD	The key training requirement for social care workers in England is an adequate induction.
Monitoring and oversight	The CQC monitors and inspects services according to every aspect of the legal duties imposed by the Regulations. Ensuring the fitness of care workers is achieved through a combination of inspections at establishments by the CQC and the provision of pre-recruitment checks on workers by the Disclosure and Barring Service (DBS). The CQC may carry out routine comprehensive inspections of adult social care services or focused inspections in response to a particular concern being raised. Inspections are based on five key questions: is the service safe, effective, caring, responsive, and well-led? Following an inspection, the CQC will rate the service "outstanding", "good", "requires improvement", or "inadequate".
Enforcement	No sanction is prescribed under the Regulations. A breach of the Regulations is not a prosecutable offence in law. However, breach of Regulation 12(2)(c) is an offence if avoidable harm results, or if a service-user is exposed to a significant risk of harm.

Related regimes	• Disclosure and Barring Service. • The Professional Standards Authority regulates self-regulators in the health and social care profession as a meta-regulator. Social work is regulated.
Evidence of effectiveness	In July 2022, the Department of Health and Social Care conducted a post-implementation review of three sets of regulations made under the Health and Social Care Act 2008. These regulations are: • Care Quality Commission (Registration) Regulations 2009 • Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and • Care Quality Commission (Reviews and Performance Assessments) Regulations 2018. The Department sought feedback from all providers of a regulated activity that are registered with the CQC in England to determine: • whether all three regulations meet their original objectives • whether their scope is still appropriate and proportionate • their impact on providers, and • whether any changes are required to achieve those objectives with a system that imposes less regulation or to change what the regulations prescribe. • The consultation received few responses – not enough to generalise responses as indicative of the whole health and social care sector. The responses were fed into a wider piece of work by the Department to review and assess proposal to amend regulations relating to CQC's oversight of regulated activities.[110]
Application to New Zealand	This would involve expansion of the role and scope of Te Kāhui Kāhu (TKK), operating as the CQC. TKK would monitor and inspect social services organisations.

[110] Department of Health and Social Care (July 2023). *Consultation outcome: Post-implementation review of regulations relating to the Care Quality Commission*. Post-implementation review of regulations relating to the Care Quality Commission - GOV.UK (www.gov.uk)

Social care workers, Wales

Regulation	Regulation of social care workers.
Regulator	Social Care Wales, the body responsible for maintaining the register, developing the workforce, and overseeing fitness to practice procedures, including disciplinary hearings. Social Care Wales has the objective of protecting, promoting, and maintaining the safety and wellbeing of the public in Wales, as well as promoting and maintaining high standards in the provision of care and support services, as well as in the conduct and practice of social care workers.
Legislation	Regulation and Inspection of Social Care (Wales) Act 2016 - under section 4 of this Act, the general objectives are to "protect, promote and maintain the safety and wellbeing of people who use regulated services" and to "promote and maintain high standards in the provision of regulated services".
Who is regulated?	Any person who provides a regulated service must be registered. It is an offence to provide a regulated service without being registered. The definition of social care workers is set out in section 79(1) of the 2016 Act, as being a person who: • engages in relevant social work (social workers) • manages a place at or from which a regulated service is provided • in the course of his or her employment with a service provider, provides care and support to any person in Wales in connection with a regulated service provided by that provider, or • under a contract for services, provides care and support to any person in Wales in connection with a regulated service provided by a service provider. Social care workers, required to be registered with Social Care Wales, include: • residential childcare managers and workers • adult care home managers • domiciliary care managers, and • domiciliary care workers.
Standards and requirements	To register with Social Care Wales, a person must demonstrate that they have the right knowledge and skills, are physically and mentally fit to practice, have the character and competence to perform the relevant role, and that they agree to follow the Code of Professional Practice for Social Care.
Education, training, and CPD	The qualifications required to register as a social care worker vary depending on the role that the individual is registered for. Following registration, all registered social care workers are required to complete 15 days or 90 hours of training and learning during each three-year period of registration.
Monitoring and oversight	Social Care Wales has a whistleblowing and complaints function and can conduct investigations.
Enforcement	Section 111(2) of the 2016 Act makes it a criminal offence for any person in Wales who is not a registered social care worker to take or use the title 'social care worker', or to imply they are registered, or to pretend to be a social care worker with intent to deceive another. Social Care Wales can suspend a worker or set conditions.
Related regimes	• Education Workforce Council (EWC) is the independent regulator in Wales for youth workers. Since April 2017, youth support workers and youth workers who provide services for or on behalf of a local authority, school, further education institution, or voluntary organisation in Wales and who hold qualifications set out in the Welsh Government legislation need to be registered with the EWC. • Organisations carrying out regulated services are required to be registered with the Care Inspectorate Wales (CIW). The CIW has powers to prosecute for

	providing a regulated service without being registered to do registered and inspection powers.
Evidence of effectiveness	The Welsh Government commissioned an evaluation of the implementation of the Social Services and Well-being (Wales) Act 2014[111], but it has not undertaken an evaluation of the Regulation and Inspection of Social Care (Wales) Act 2016. There have been subsequent amendments to regulations: • 2020: to mandate the registration of domiciliary care workers from 1 April 2020 and the requirement for service providers to only employ those who are registered with SCW.[112] • 2022: to mandate the registration of social care workers in adult care homes and family residential centre services from 1 October 2022 as well as a requirement on service providers to only employ those who are registered.[113]
Application to New Zealand	Social Workers Registered Board (SWRB) would register social workers and category 3 workers. Service providers would only be allowed to employ and/or engage under a contract for services only those individuals who are registered with SWRB. Te Kāhui Kāhu (TKK) would operate like Care Inspectorate Wales. Social services organisations would need to be registered with TKK. TKK would have powers to prosecute organisations who employ unregistered workers.

111 Welsh Government (2023). Evaluation of the Social Services and Well-being (Wales) Act 2014. https://www.gov.wales/evaluation-social-services-and-well-being-wales-act-2014-overview

112 Department of Health and Social Services (2020). Welsh Government integrated impact assessment summary: Regulation and Inspection of Social Care (Wales) Act 2016 and Regulated Services (Miscellaneous Amendments) Regulations 2020 https://www.gov.wales/sites/default/files/publications/2020-02/regulation-and-inspection-of-social-care-wales-act-2016-and-regulated-services-miscellaneous-amendments-regulations-2020.pdf

113 Department of Health and Social Services (2022). Impact assessment: Regulated Services (Service Providers and Responsible Individuals) (Wales) Regulations 2022 ("the 2022 Regulations"). mandatory-registration-of-adult-care-home-workers-integrated-impact-assessment.pdf (gov.wales)

Social service workers, Ontario, Canada

Regulation	Regulation of social service workers
Regulator	Ontario College of Social Workers and Social Service Workers
Legislation	Social Work and Social Service Work Act, 1998
Who is regulated?	The Act restricts the use of Social Service Worker and Registered Social Service Worker title (generally, holders of a two-year certificate in social services from a community college). Social service workers assist clients in dealing with personal and social problems by delivering counselling, community services, and social support programs. Regulations under the Act define the role of a social service worker as: "a person who assesses, treats, and evaluates individual, interpersonal and societal problems through the use of social service work knowledge, skills, interventions, and strategies, to assist individuals, dyads, families, groups, organizations and communities to achieve optimum social functioning." The scope of practice for social service work is defined here: https://www.ocswssw.org/sop/scope-of-practice-for-social-service-work/ Individual who use the protected titles illegally or who hold out as if they are a social worker or a social service worker are considered unregulated practitioners and put the public at risk. The College publishes a list of individuals who are not registered members of the College.
Standards and requirements	The College sets standards of practice and ethics. These cover scope of practice, relationships with clients, competence and integrity, responsibility to clients, the social service work record, confidentiality, fees, advertising and communication, and sexual misconduct.
Education, training, and CPD	The formal training for a social service worker is an approved diploma from a two-year program (or accelerated equivalent) offered at an Ontario College of Applied Arts and Technology (CAAT); students will spend approximately 500 – 700 hours in field placement throughout their programme, or have a combination of academic qualifications and experience that is substantially equivalent to a social service worker diploma. The Continuing Competence Program (CCP) is mandatory for all registrants of the College. The CCP promotes quality assurance for the practice of the professions of social work and social service work, and encourages registrants to enhance their practice in an ongoing way. This is one way the College fulfils its mandate of public protection. The college also oversees professional qualifications and certification.
Monitoring and oversight	The College maintains a registry of members, receives mandatory reporting from employers, and receives and investigates complaints.
Enforcement	The College disciplines members for professional misconduct or incompetence.
Evidence of effectiveness	In 2005, the Ministry of Community and Social Services (MCSS) conducted a 5-year review of the Social Work and Social Services Work Act 1998. The review posed two questions:[114] • Are the provisions in the Act adequate for achieving the objectives of the Act (such as public protection, quality social work and social service work services, and accountability)? • What changes to the Act, if any, should be considered by the government to improve the operations of the College in carrying out its roles and responsibilities?

[114] Ontario Ministry of Community and Social Services (2005). Review of the Social Work and Social Service Work Act 1998 – discussion paper. Microsoft Word - SWConsultation Paper-revised 3_oct25_DR_RL.doc (ocswssw.org)

	97 submissions were received and there were three key Ministry positions resulting from the consultation:[115] • The College to retain responsibility for defining scopes of practice in its by-laws and may amend the by-laws in response to the professions' needs. • To not support scope of practice to be explicitly defined for both social workers and social service workers in the Act. • To not change the governance model. Currently the Act dictates that there are seven elected social workers, seven elected social service workers, and seven public appointees on the College Council. Some stakeholders would like to increase the social worker representation on the College Council to better reflect their 90% membership or establish separate colleges for the two professions. At that time, there were 10,000 social workers and 1,000 social service workers registered. The Ministry believed that there would be growth in social service workers over time.
Application to New Zealand	Category 3 workers would be required to register with the Social Workers Registration Board (SWRB). SWRB would publish a list of people who are not registered social workers or registered category 3 workers. Title protection and negative registration.

[115] Ontario Ministry of Community and Social Services (2006). Review of the Social Work & Social Service Work Act, 1998. http://www.mcss.gov.on.ca/NR/rdonlyres/44CCCD1D-A60C-440B-B646-EF98047E9296/649/minReport_en_SWSSWA.pdf

Domestic, analogous workforces

Enrolled nurses

Regulation	Regulation of enrolled nurse
Regulator	Nursing Council – the Council's statutory role is to protect the health and safety of the public, and the scopes that describe the profession are part of the foundation for that protection.
Legislation	Health Practitioners Competence Assurance Act 2003 (the Act)
Who is regulated?	Enrolled nurses: • Enrolled nurses practice under the direction and delegation of a registered nurse or nurse practitioner to deliver nursing care and health education across the life span to health consumers in community, residential, or hospital settings. • Enrolled nurses are accountable for their nursing actions and practice competently in accordance with legislation, to their level of knowledge and experience. They work in partnership with health consumers, families, whānau, and multidisciplinary teams.
Standards and requirements	Enrolled nurses must: • demonstrate competency against the Council's Competencies for the enrolled nurse scope of practice • be deemed to be fit for registration (section 16, Health Practitioners Competence Assurance Act 2003), and • complete the 18-month diploma of enrolled nursing (level 5 on the New Zealand Qualification Authority framework).
Education, training, and CPD	Under the Health Practitioners Competence Assurance Act 2003, students seeking registration as an enrolled nurse must meet the following requirements: • complete the theoretical and clinical experience requirements of an accredited programme in the enrolled nurse scope of practice, and • pass the State Final Examination for enrolled nurses. The Council has a statutory role in determining if students can be registered.
Monitoring and oversight	The Council receives complaints and concerns about nurses and will investigate where necessary. The HDC provides an alternative avenue.
Enforcement	When a nurse fails to meet the required standards of nursing, the Council will investigate and depending on the nature of the issue either aid them in meeting the standards or, if necessary, follow disciplinary processes.
Related regimes	• Registered Nurse • Nurse Practitioner • Health and Disability Commission
Evidence of effectiveness	In December 2022, the Nursing Council released a consultation document to review the enrolled nurse scope of practice. The Council wanted to ensure that the scope of practice reflects contemporary and emerging research, policy, and best regulatory practice.[116]

[116] Nursing Council of New Zealand. (2022). Consultation document: Review of the enrolled nurse scope of practice statement. EN Scope Statement Consultation (nursingcouncil.org.nz)

	In October 2023, the Nursing Council sought views on proposed changes to the nursing education programme standards leading to registration as an enrolled nurse.[117] This was required to support the broadened scope of practice that resulted from the scope of practice review.
Application to category 3 workers	Category 3 workers would be registered with SWRB with a corresponding scope of practice, and detailed competencies and education standards. Mechanisms for registration, monitoring, and complaints would need to be established and implemented.

[117] Nursing Council of New Zealand. (2023). Enrolled nurse education standards consultation. Enrolled Nurse education standards consultation (nursingcouncil.org.nz)

Engineers

Regulation	Proposed registration and licencing of engineers
Regulator	A new Board would be established to oversee the regime.
Legislation	Currently being drafted.
Who is regulated?	Registered engineers – all engineering disciplines. • Licensed engineers – services in high-risk engineering practice fields. • Engineering associates – voluntary registration of engineering technicians and technologists under a separate register.
Standards and requirements	To maintain registration, registered engineers would: • be subject to a code of ethical conduct, established through regulations • required to meet prescribed professional development requirements, as set out in rules developed by the Board and approved by the Minister for Building and Construction, and • required to make an annual declaration that they have met the above requirements in order to maintain registration.
Education, training, and CPD	Board to set the eligibility requirements for registration through rules. Registration would also require professional development.
Monitoring and oversight	The Board would have the power to audit a licensed engineer's work, both randomly or as part of an investigation into an engineer's conduct. An engineer may be referred for disciplinary action as a result of an audit. Board may carry out audits of a registered person's professional development records. The Board would be able to audit an engineer's professional development records, and may request that an engineer submits their records of professional development.
Enforcement	A robust complaints and disciplinary process will be used to ensure engineers are held to account for poor practice or performance and that the public has confidence in the profession. It would become an offence to provide professional engineering services without being registered or to claim to be registered when one is not, fineable upon conviction up to $10,000. It would become a criminal offence to carry out or supervise restricted engineering services without a licence, or to breach any conditions of the licence. A person convicted of such an offence would be liable to a fine of up to $50,000. It would also be a criminal offence to knowingly engage someone who is not licensed to undertake restricted work. An individual may be fined up to $50,000 or a body corporate may be fined up to $150,000 upon conviction.
Evidence of effectiveness	Not applicable. Not yet in force.
Application to category 3 workers	Category 3 workers would be able to be voluntarily registered with the SWRB, under a separate register. Mechanisms for registration, monitoring, and complaints would need to be established and implemented.

Legal executives

Regulation	**Voluntary membership of the New Zealand Institute of Legal Executives**
Regulator	New Zealand Institute of Legal Executives (NZILE)
Legislation	None although recognised in: • Section 94A of the Protection of Personal and Property Rights Act 1988 – provides declarations may be made before a fellow of the NZILE, and • Section 9 of the Oaths and Declarations Act 1957 – provides a fellow of the NZILE are entitled to witness statutory declarations.
Who is regulated?	Legal executives Legal executives are not qualified as lawyers; however most hold the New Zealand Diploma in Legal Executive Studies or its predecessor, the New Zealand Law Society Legal Executive qualification. Legal executives are skilled in one or more aspects of law and attend to a wide range of legal work, generally specialising in one or more of the following: residential and/or commercial conveyancing, estate administration, trust formation and administration, estate planning, and some aspects of litigation. Experienced legal executives can achieve a high degree of autonomy and independence. Their work is people-oriented and requires them to have the same high ethical standards as lawyers. They are told many things in confidence and have to apply tact, sympathy, patience, and understanding to resolve clients' problems and give appropriate advice.
Standards and requirements	Levels of membership Affiliate members: • They are qualified and meet the institute's qualifying employment criteria: Employed as a legal executive for at least 15 hours per week if working part-time. • Working under the supervision of a lawyer who holds a current practising certificate. • Doing at least 70% legal executive work if their role includes other aspects of legal work such as personal assistant, practice manager, trust accountant. • Affiliate members who have been employed as a legal executive for at least 12 months may witness donor signatures to enduring powers of attorney under section 94A of the Protection of Personal and Property Rights Act 1988. Associate members • Same as affiliate but must have been affiliate members for 3 of last 5 years and complete 8 hours of CPD. Fellow members • Same as affiliate but must have been affiliate members for 5 of last 8 years and complete 10 hours of CPD. • Fellows can also witness statutory declarations under section 9 of the Oaths and Declarations Act 1957 and they are 'trusted referees' who may certify identity verification documents under the Amended Identity Verification Code of Practice 2013. Persons registered as members of The New Zealand Institute of Legal Executives Inc (the Institute) become bound by its rules. They must: • support the aims and objects of the Institute, and • uphold the standards of professional practice prescribed in the Code of Ethics.

Education, training, and CPD	Must hold a Legal Executive Diploma to be registered. Affiliate members are required to complete at least six hours of CPD in each membership year as one of the prerequisites for renewing their annual registration.
Monitoring and oversight	Required to submit a declaration stating CPD requirements have been met for the preceding 12-months. May be randomly selected for a CPD audit to check compliance with the requirements.
Enforcement	Disciplinary process: Any member who is guilty of conduct unbefitting a member in the course of their employment or who wilfully commits any breach of the constitution or the professional conduct rules may be censured, suspended, or expelled from membership of the Institute.
Related regimes	Lawyers: A representative of NZILE sits as an observer on the Law Society Council.
Evidence of effectiveness	An independent review of the statutory framework for legal services in Aotearoa New Zealand was commissioned in December 2021.[118] The review was in response to concerns that the complaints process was no longer fit-for-purpose and was not serving the public or the profession well. The independent review was released in March 2023.[119] NZILE was engaged with as part of the review. NZILE highlighted that the Lawyers and Conveyancers Act 2006 regulates the activities of individuals who are employed by lawyers. By virtue of sections 11 and 14 of the Act, employees of lawyers are subject to the same minimum standards, regulatory oversight, and complaints service as lawyers – but they do not have any recognition, representation, or formal status under the Act. It was submitted the Act needs updating to provide for statutory recognition of these employees and enable more tailored regulation. Further, the Panel noted that regulation of lawyers' employees could be done in a more proportionate and transparent manner (rather than the same standard of a qualified and practising lawyer). Any new legislation should grant the regulator the power to tailor regulations governing the behaviour of employees. This would allow regulations to more appropriately reflect the different roles and levels of experience of employees within a workplace and would clarify regulatory expectations of those employees. Key recommendations from the review were the establishment of a new independent regulator to regulate lawyers, and an overhaul of the system for handling complaints about lawyers. The review panel found that the dual functions of the Law Society as a regulator and membership body did not serve the interests of the public or profession well. Note that in England and Wales, a super-regulator, the Legal Services Board, was established and tasked with overseeing nine approved regulators, including the Solicitors Regulation Authority for lawyers, and Chartered Legal Executives for legal executives. The Independent Review Panel did not recommend adopting functional separation in New Zealand. Additionally, the Panel noted that there are increasing calls in England and Wales to establish a single unified and independent regulator.
Application to category 3 workers	No new legislation required. Regulation through existing mechanisms, for example, through Te Kāhui Kāhu and contracts. A new, voluntary, professional association for category 3 workers.

[118] New Zealand Law Society. (2021). Independent review of the statutory framework for legal services in Aotearoa New Zealand – Terms of reference. Independent-review-terms-of-reference.pdf (lawsociety.org.nz)

[119] Independent Review Panel. (2023). *Regulating lawyers in Aotearoa New Zealand*. Regulating-lawyers-final-report.pdf (lawsociety.org.nz)

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