Navigating the maze of DHB locality authorisation

Patrick Bartosch

As a remote, first-year PhD student in health sciences at the University of Otago, I have become used to managing a variety of challenges that the global pandemic has brought along with it: taking calls in the middle of the night (I live in the Netherlands, waiting for New Zealand to open its borders), getting together with my supervisors via Zoom only (we have yet to meet in person) and navigating the bureaucratic landscape of gaining ethics approval and applying for scholarship and funding at the university while being outside of the country. All of this I expected when I started the programme in November 2020.

What I did not expect was the rather dysfunctional procedure of gaining locality authorisation from four district health boards (DHBs): Auckland, Canterbury, Capital & Coast and Southern. I started the process of applying for locality authorisation in April 2021 and, just this past week (September 2021), received approval from the last DHB. My research is as low-risk as it gets—I am talking to healthcare providers and patients about their experience within the healthcare system. I am not asking for clinical information. I am not taking samples. I am not testing new compounds on people. I am only talking to a handful of people in each district. And yet, the process of pursuing locality authorisation was cumbersome and needlessly frustrating.

The one thing that confuses me the most is how the process of receiving locality authorisation differs depending on the district. One district classified my research as "ultra-low risk" and I did not even need to apply for locality authorisation. Another also classified it as "ultra-low risk" and yet I had to submit six different forms of documentation and still go through the entire approval process. The other two districts did not even offer the option of labelling it "low risk," meaning I had to go through the whole cumbersome process, which took months each time.

Two DHBs asked me to identify clinical leaders for the service lines that I planned on including in my research and to get their signatures on the authorisation form. One DHB was kind enough to provide me with a list of these clinical leaders, but the other just emailed me a friendly "Good luck!" in finding them—from the Netherlands. The clinical leaders are not listed on that DHB's website and several emails from me to the DHB research office asking for their names and contact details went unanswered. I ended up emailing random physicians listed on the service web pages, asking them who their clinical leaders were.

Ultimately, all but one DHB asked me to find someone among their employed physicians to sign the form as a Principal Investigator (PI), a formality that has no impact whatsoever on my research as these PIs don't have to do anything else but sign the form. For low-risk research, this is a bureaucratic requirement that serves no purpose beyond causing additional work to me as the researcher. I asked a member of the research office at one DHB for a PI in their district whom I could approach, but they could not help me and instead referred me to my supervisors (who are from a completely different district) for advice on identifying a PI.

As a foreigner who was not familiar with the New Zealand DHBs before starting the programme, this process has caused me headaches. And it has also been very confusing, as many of the steps towards receiving locality authorisation make no rational sense at all. They appear to be bureaucratic principles that were once introduced and, apparently, have not been seriously questioned since. They also cause unnecessary work not just for me as a student, but also for the DHBs. My research will not significantly or directly affect the

DHBs, their employees or the patients they serve.

The sad truth is that the current processes of gaining locality authorisation are discouraging researchers from conducting valuable research. They are a hurdle that is utterly unnecessary (no comparable processes exist in the other two countries included in my project). If locality authorisation is indeed necessary, the process should be coherent and pragmatic. Currently, it is locking researchers who are not from within the system out of the research ecosphere. International students may decide to take their research elsewhere, which would be a shame for New Zealand and for patients who may ultimately benefit from the research.

I understand why these processes were introduced in the first place, but there has to be a way to make them more reasonable and faster. If a research project is ultra-low risk, as is the case with mine, I should not have to go through full-scale locality authorisation. As New Zealand embarks on significant healthcare reforms over the next year, with the introduction of Health New Zealand and the merger of the DHBs by the middle of 2022, there is a real opportunity to improve on some of these processes.

I hope receiving locality authorisation from Health New Zealand will be a much more streamlined and simple process. The first question that should be answered and evaluated is: What is the risk associated with a research project? If the risk is low, then locality authorisation should be quick and brief. And it should be the same across all of New Zealand. One central approval procedure should be introduced. This would not only help students and researchers. It would also save Health New Zealand employees a lot of time.

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