The New Zealand Health Workforce

Future Directions – Recommendations to the Minister of Health 2003
Foreword

The recommendations presented in this report reflect both the brief to the Health Workforce Advisory Committee (HWAC) to advise the Minister on strategies to develop an appropriate health and disability workforce capacity, and HWAC’s belief that such advice must address fundamental systems issues in our health sector.

The committee acknowledges with gratitude the significant and sector-wide engagement in the consultation processes that have helped shape these recommendations. The health workforce faces formidable challenges, but the determination HWAC has encountered, right across the sector, to develop and implement strategies which will enable health practitioners to fulfil their roles more effectively, is perhaps the key prerequisite for constructive change.

Workforce development is a social process, with the stimulation and tensions of shared involvement in evolution of roles and services. The recommendations that follow provide a foundation and framework for strategic development of our health workforce. We commend them to you, and look forward to continuing shared involvement in this process.

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Introduction

The Health Workforce Advisory Committee (HWAC) is tasked with providing strategic advice to the Minister of Health on the health and disability workforce (see HWAC Terms of Reference below).

The Government’s policy documents clearly set out its strategic vision for the development of health and disability services. Key elements are:

• the Treaty of Waitangi
• a public health and primary care focus to development
• equitable and affordable access to services
• reducing inequalities
• a safe, high performing and efficient health system
• active user and community engagement.

This vision has guided HWAC’s deliberations.

Since it began in 2001, HWAC has:

• undertaken and published a stocktake of current workforce capacity and issues (HWAC 2002a)
• released a discussion document setting out its initial thinking about future directions for the health workforce (HWAC 2002b)
• sought and analysed submissions (HWAC 2003)
• consulted widely
• held a national summit in March 2003, broadly representative of leading thinkers on health and disability workforce issues.

This document consolidates HWAC’s advice to the Minister of Health after its first full round of consultation.

Health Workforce Advisory Committee Terms of Reference

HWAC’s key tasks are to:

1. provide an independent assessment for the Minister of Health of current workforce capacity and foreseeable workforce needs to meet the objectives of the New Zealand Health and Disability Strategies
2. advise the Minister on national goals for the health workforce and recommend strategies to develop an appropriate workforce capacity
3. facilitate co-operation between organisations involved in health workforce education and training to ensure a strategic approach to health workforce supply, demand and development
4. report progress on the effectiveness of recommended strategies and identify required changes.
The legacy

Organised health workforce planning and development began in New Zealand in the 1970s. For more than a decade information systems, networks and planning processes were methodically put in place. These were largely dismantled and abandoned during the health sector reforms of the late 1980s and early 1990s. The contention was that competition and market forces would drive the sector, including health workforce development. By the late 1990s it was clear that these laissez-faire arrangements were not working well. The competitive ethos discouraged information sharing and co-operation between service providers and other elements of the workforce. Expected quality and productivity gains either did not arrive or were slow in coming. Residual fragmentation, frustration and anger from this period were reflected in feedback to the committee’s stocktake of workforce capacity and issues.

HWAC found:

• a degraded infrastructure to support health workforce planning and development
• an inadequate information base in most respects
• poor communication and co-operation between stakeholders
• narrow, siloed thinking in work settings and occupational areas
• unhealthy and sometimes dysfunctional work environments
• little trust in political, managerial and health professional leadership
• a fragmented, confused and, in places, demoralised and angry workforce protective of parochial interests and cynical and fearful of further change.

The sector strongly identified with the positive and negative performance spirals (Appendix 2) summarising organisational culture presented in HWAC’s future directions discussion document which built on sector feedback to the stocktake.

Key messages

The following are the key messages HWAC wishes to convey from its first full round of consultation.

A vision for the health workforce must be grounded in a national vision for health and disability services which sees these as a whole, rather than a set of separate services. To achieve the Government’s strategic goals requires major change in the way that health is protected and promoted and the way that treatment and supporting social services are organised, planned and provided. Given the Government’s stated strategic intentions many of the present arrangements, including workforce arrangements, are not appropriate or sustainable. A major culture change (or paradigm shift) is required.

The provision of health and social services is hugely complex. Modern health and information technologies have enormous positive potential for health sector and health workforce development. The challenge is to harness this potential in ways that are affordable and fair, and enable the population, as a whole, to share in the benefits.
The potential for saving and prolonging life with modern and often expensive technical interventions must be balanced with population-based initiatives. These initiatives must encourage and enable people to become better informed about, and more capable of, protecting and promoting their own health and the health of their families and communities. Workforce development has been focused historically around hospital-based medical specialties. This remains a crucial area of workforce development but must be complemented by increased attention to workforce challenges in the delivery of public health, primary and community-based care if the sector is to respond effectively to emerging needs and trends, including a more strategic approach to prevention and early intervention.

For this to happen the focus of the whole system must shift and become more firmly fixed on what the users of health services and their associated communities want – a person- and community-centred approach. In the past health professionals and the providers of services have dominated health sector decision-making. The focus has been mainly on hospitals and treatment services – primary care, public health, mental health, disability support-and sensitivity to cultural and community needs have often been after-thoughts. This must change, and is changing, in both institutional and community settings.

Strong support for an integrated primary health care approach is evident in the Government’s commitment to the development of Primary Health Organisations (PHOs). The challenges, including the workforce challenges, are enormous. Ways and means must be found to actively engage the local users and providers of services, and their associated communities, in the governance and management of PHOs.

Health system complexity is such that actions taken in one part of the system often have unexpected and sometimes unwanted consequences elsewhere. In this sense the system is organic and is said to be more akin to a living system such as a frog than to a mechanical or compartmentalised system such as a bicycle (Mant 1999). In other words it is more than the sum of its parts. Change in organic systems is generally slow. It can be guided and encouraged but may respond in unfortunate and unpredictable ways to efforts (however well-informed and intentioned) to command and control the system.

This requires new thinking about the roles and responsibilities of those involved in the governance, planning, management and delivery of services. New ways must be found to network resources. Health practitioners must learn to work in teams whose aim is to provide safe, high-quality, integrated and well-managed care that makes best use, in the widest sense, of all the resources a community has to commit to health. The population health approach, which considers the determinants of health, also places demands on all health practitioners for the skills to deliver such an approach. To achieve this will require changes to the way health practitioners are trained and deployed, and to the way they work. A broadly based whole systems approach is required.

Information and linear modelling of parts of the system are essential to supporting health sector decision-making. But, the complexity of health systems is such that linear modelling alone is not sufficient. There are, for example, no health workforce development models that can be used to predict with confidence workforce requirements more than two to three years out (Bloor and Maynard 2003). The current nature and pace of change severely limits the utility of such models for workforce planning. This is not an argument against so-called ‘evidence-based policy and planning’ but it does raise questions about what evidence and whose evidence is relevant to the planning process.
If we seriously intend to involve local health practitioners and their associated communities in the governance and planning of health and disability services then we must recognise that communities are diverse – ethnically, culturally, socially and economically. They have their own history, their own resources, their own leadership and their own unique ways of doing things. They have their own ways of perceiving health and the factors that contribute to health and wellbeing. Often they are relatively uninformed on the technicalities of health and health service delivery but may have firm ideas about what health is, what and how health and disability services should be provided, and what rights and responsibilities they as citizens, and as a community, have to protect and maintain health development.

What a community has to offer, and is willing to do for itself, often depends upon the extent to which health services engage with local communities. Front-line health practitioners have a critical role to play in this context. The success of a PHO may well depend upon the extent to which health practitioners are able to engage, inform, motivate and work with their local community.

Given the uniqueness of communities and the limitations of both generalised models and top-down management, the way in which the health and disability sector is governed is vitally important. What is required at the centre, and what the Government has provided, is a clear vision for the health system it wants. The Government has outlined the principles and the approach to the changes in the system it wishes to see. These are the principles and the approach the Government expects all communities to apply in designing and developing service models, including workforce models, from now on. These are best provided as guidance, not direction. This guidance is presented to inform local consultation and deliberation, to stimulate discussion and debate and to facilitate local innovation and decision-making.

The balance between what the centre provides by way of guidance, direction, control and audit and what is better left to local deliberation and decision-making is also vitally important. As well as providing policy and technical advice the central authorities provide a national service framework for the allocation and use of resources and for clinical and financial accountability. These should not unnecessarily constrain efforts to innovate locally and to respond to the ideas and wishes of local health practitioners, local service users and local communities. The approach of central agencies should be more informative and technically supportive, more consultative and collaborative in its initial form, with intervention if minimum standards are not met.

Traditionally New Zealand has looked overseas for inspiration and innovation in the design and delivery of health services and in workforce development. This has served us well and should continue. But, as a maturing and more independent society in an increasingly complex and globalised world, we must look more to the unique features and requirements of our own society. In its work HWAC has seen many examples of excellence in innovation and service development, particularly among Māori and Pacific peoples, but also in fields such as aged care, mental health, disability support, public health and many others. What we are not good at doing is encouraging, recognising and rewarding local innovation and excellence, sharing the experience and learning from it. It is pleasing to see that we may have started to do this by way of the recent Health Innovation Awards.
More support is required for research, evaluation and development activities specifically aimed at encouraging local innovation and locally driven health sector development. Such activities should aim to:

- engage and network health practitioners and researchers with local communities
- respond to local ideas and aspirations
- engage the local providers of education and research services
- encourage and facilitate teamwork
- improve communication and build bridges between organisations and practitioners
- share experience and learning
- contribute to the redesign of services and the workforce
- contribute to policy development, locally, regionally and nationally.

In keeping with this general philosophy of change and change management some restructuring and redesign of services and of the workforce will be needed. Some totally new roles and ways of working will emerge. But, in large part it should be possible to evolve the required changes by working within existing occupational structures and workforce arrangements. The extent to which the existing workforce and its supporting structures are willing and able to evolve and meet new challenges will determine how assertive legislative and other measures aimed at promoting change will need to be. An important consideration here is the Health Practitioners Competence Assurance (HPCA) Bill currently before Parliament.

What HWAC is talking about is evolved change in a complex social system. It is a complex organic process that will take time and should not be rushed. It can be guided, facilitated and encouraged but will not respond well to doctrinaire prescription particularly if that is aimed at forcing unjustified conformity on the system. HWAC therefore offers its advice as guidance for evolved change.

General considerations

HWAC’s recommendations have relevance for the Ministers and the Ministries of Health and Education (including the Clinical Training Agency [CTA]), District Health Boards (DHBs) and the District Health Boards New Zealand (DHBNZ), public, private and third sector providers of health and education services, the health professional organisations, registration bodies, and health sector unions.

1 The Health Innovation Awards programme aims to: encourage continual improvement of care and services in the health and disability sector; recognise those who have developed and implemented innovations that are sustainable examples for improving health outcomes, support and independence; celebrate success and excellence; and identify initiatives that are transferable and promote a sharing and learning environment. The awards have been initiated jointly by the Ministry of Health and the Accident Compensation Corporation and are being independently evaluated by the New Zealand Business Excellence Foundation. http://www.healthinnovationawards.co.nz
Health workforce development is a complex, multi-dimensional, interdisciplinary total system activity (Appendix 3). To get the whole system evolving in the desired direction it is essential that each component is integrated as part of the total system. This requires much greater clarity than currently exists about the roles, responsibilities and accountabilities of each individual component of the network. For each element the core functions must not only be clearly defined but also be widely communicated and understood. HWAC has an advisory role as defined in its Terms of Reference but the task of overseeing and co-ordinating the work of the whole system must fall to the Ministry of Health.

To support the implementation of these recommendations and to help address other issues within its Terms of Reference HWAC intends to involve health practitioners. Over time HWAC will convene a series of reference groups with specific expertise. Initially a group with medical workforce expertise will be brought together to help address the implications of these recommendations for the medical workforce.

The DHBs and DHBNZ have an increasingly important role to play in health workforce development. In the past this was somewhat neglected by their organisational predecessors. The role, with some exceptions, fell almost entirely to educational institutions and the organised health professions. With leadership from DHBNZ there is huge potential for the DHBs to work more closely together not only with each other but also with the educational and professional interests.

HWAC acknowledges the work that is under way by DHBNZ on improving workforce information and the development of a joint DHB/DHBNZ Workforce Action Plan. These recommendations give direction to DHBs on the priority workforce issues to address within their workforce development plans, and signal areas for future workforce development.

Non-government organisations (NGOs) are often at the cutting edge of innovation and development in the provision of both health and disability and education services. The all-round capability of many people in these organisations means that they have the flexibility, initiative, energy, enthusiasm and the opportunity to innovate in ways that are often not easily available to those in main-line services. Not nearly enough use is made of NGOs in this context and forums for sharing these innovations are important.

The education sector and its interface with the health sector are crucial to achieving a workforce responsive to these new directions. The summit HWAC held in March 2003 demonstrated a strong willingness by the sector to work on this intersectoral engagement and ensure that relationships between the health and education sectors at all levels are strengthened for the benefit of health practitioners and communities.

HWAC has not costed its recommendations. Many are relatively low-cost strategies and may be implemented within existing health sector funding. The sector is funded via a three-year funding pathway that makes provision for annual funding increases. This mechanism provides an opportunity to start addressing the recommendations. There is a cost to doing nothing. Initiatives that improve staff satisfaction and careers should pay dividends, for example, through improved retention. Funding is already being targeted at some areas highlighted in this report and may also need to be used to give workers incentive to consider doing things differently. In some cases current funding decisions or work priorities may need to be reprioritised to implement these recommendations.
Significant increases in the public funding of health services have recently occurred, or are planned, in western countries with health systems similar to New Zealand\(^2\). More resources would be helpful but will not necessarily lead to desired health improvements or better value for money invested in health and disability services. If there is to be new money in the system it must be used strategically to guide the system in the desired direction. Experience both internationally and in New Zealand shows that when new money does come into health systems it often does so quickly and unannounced. Much can be done, and will need to be done, within existing resources but we should be thinking and planning now as to where and how new resources for health workforce development should be invested, should the opportunity arise. These recommendations identify priority areas for investment.

HWAC’s recommendations are at two levels. First, there are recommendations that are strategic and mainly concerned with desired changes to the culture of the health system. Second, there are recommendations that relate more directly to operational issues. Actions on both levels are essential to fulfil the strategic vision for development of health and disability services.

**Health workforce development priorities**

HWAC has organised its work in six key areas. These are: the health workforce implications of the Primary Health Care Strategy; the development of healthy workplace environments; the evolution and further development of health workforce education; Māori health workforce development; Pacific health workforce development; and the evolution and development of the health and support workforce to better meet the needs of disabled people. A seventh area has now been added on research and evaluation. Within each of these areas the general philosophy and principles of change and the general considerations set out above apply.

HWAC has identified an overall goal and recommendations for the seven priority areas. The challenge to the health and disability sector is to continue to work in partnership to implement these recommendations. By collaborating and working together there is likely to be a greater degree of agreement and ownership to the policy direction taken to achieve the vision outlined for the health sector in the New Zealand Health and Disability Strategies.

**Goal**

To recruit, train, employ, deploy and retain a health and disability workforce appropriate to meet the diverse needs of all New Zealanders in the short, medium and long term.\(^3\)

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\(^2\) For example, the £835 million increase in funding over three years announced in 2001 in the UK. Of this investment, £135 million was targeted at new financial packages for nurses and GPs.

\(^3\) Dr Peter Leslie, Council of Medical Colleges.
Seven Priority Areas for Health and Disability Workforce Development

1. To address the health workforce implications of the Primary Health Care Strategy

Implementation of the Primary Health Care Strategy presents the whole sector with a range of health workforce development challenges. The strategy is targeted at reducing inequalities, engaging communities, improving health service delivery and improving health outcomes. The evolution of primary health organisations will challenge health practitioners to work in new ways, with new knowledge, skills and changed mindsets, to ensure that individuals, families and communities receive high-quality, integrated care and continuity of care, as close to home as possible.

Hierarchical ways of working will need to change in favour of working in networks and effective teams to optimise co-ordination of care of individuals and their families. Depending on the size and nature of the community served, PHOs are likely to employ health practitioners from a variety of disciplinary backgrounds and with varying levels of relevant experience. The precise mix of disciplines is not as important as the combined knowledge, skills and attitudes of the group and the willingness and ability of members to work together as a team to achieve shared objectives and desired health outcomes.

Co-operation and mutual respect from the various health and disability service provider groups with regard to recognising interdisciplinary scopes of practice will be important. New relationships will have to be built not only with community partners but also with colleagues in hospitals, in education, with public health providers, and in other settings.

Strong leadership at both PHO and DHB level will be important to the success of these organisations. The existing primary health care workforce will need to be involved in discussions about the best practice required and the changes the workforce is required to make to achieve new models of care. Participants at HWAC’s summit proposed a set of principles for health workforce development, emphasising leadership, shared governance, stakeholder involvement, collaboration and shared learning. Sharing successful innovations and evaluation of new models of care will be necessary.

Ways and means will be required to encourage and support the leaders of pioneering PHOs. Leaders will need assistance to capture, document and share their insights and their experiences and to learn from and support each other. This may be done by way of mentoring and other forms of support, by workshops, forums, learning sets, retreats, exchanges and more formal learning activities.

District Health Board workforce development plans will need to look to future requirements, develop ways to reduce barriers to participation, and act as incentives to attract people to work in the primary health sector. The plans should be inclusive and enabling, and acknowledge and value the diversity of skills and attributes different people bring with them to the sector. Recognition of prior learning and access for students to appropriate clinical placements in population and primary health environments needs co-ordination and support by health service providers.
Those responsible for setting up PHOs have a difficult task because they must put into operation what is still a fairly general concept, and mould it using the available resources to meet the needs and aspirations of the local health workforce, health service users and the community, and at the same time meet central accountability requirements. This will be difficult and will require active collaboration with and the support of all concerned, including the existing workforce.

There clearly is a need for central guidance, information and technical support but each PHO will have to take that guidance and find its own way of relating to its workforce and its community.

To address the health workforce implications of the Primary Health Care Strategy, HWAC recommends that:

1.1 the Ministry of Health:
   1.1.1 requires DHBs to include the primary health care workforce in their workforce development plans by June 2005
   1.1.2 promotes and appropriately resources collaborative workforce practice within the health and disability sector to achieve the goals of the Primary Health Care Strategy

1.2 DHBs:
   1.2.1 advance the particular needs of community health practitioners, support workers and volunteers
   1.2.2 strengthen consultation processes with local employer and employee stakeholders during the implementation of the Primary Health Care Strategy
   1.2.3 progress workforce development plans which acknowledge and reward the diversity of skills and attributes of all primary care workers
   1.2.4 strengthen working links with local and regional education and training providers to ensure health workforce education is aligned with health service delivery
   1.2.5 actively promote the population health approach in primary health care service delivery
   1.2.6 actively promote the use of public health, allied health and community health workers to deliver early intervention strategies in PHOs
   1.2.7 prepare and promote policies and plans to support governance, clinical leadership and management functions in primary care
   1.2.8 explicitly invest in components of workforce development, including ongoing training, support, teamwork, mentoring and leadership development
   1.2.9 use a broad range of incentives and frameworks to attract and retain health and disability workers to primary health, particularly in rural and socioeconomically disadvantaged areas
   1.2.10 share developments and innovations for using workforce resources wisely

1.3 the Tertiary Education Commission (TEC) consults with HWAC and the Ministry of Health about emerging models of health practice and utilisation of health practitioners.
2. To progress the development of healthy workplace environments

Healthy workplace environments are a prime requirement for health workforce development. HWAC’s stocktake of issues suggests that many health sector workplaces in New Zealand are currently far from healthy. We are not alone in this, but sharing the challenge with other countries makes it no less significant or urgent.

Healthy workplace environments are everyone’s responsibility. Workplace environment issues must be addressed at all levels and across the whole system, with a central focus on values, processes of engagement and nurturing the workforce. Enthusiasm, co-operation, teamwork and commitment to innovation, continuing education, shared learning and career development are all features of a healthy workplace. This area will continue to be a focus in HWAC’s future work programme.

At the summit, sector-wide feedback indicated strong support for the development of a set of national guidelines by relevant stakeholders against which healthy workplaces could be measured. All health providers would be required to ensure transparent processes for their workforces to assess their organisational performance against such guidelines.

To meet future demands on the health system increased focus on recruitment and retention of skilled health practitioners will be important. Practitioner groups have raised this as a particular concern. Ensuring healthy workplace environments will be key to achieving this goal and a specific role for the proposed reference groups will be to assist HWAC in this area although their tasks will be broader than this.

To encourage healthy workplaces and promote health workforce development effective organisational leadership must be engaged, exercised and encouraged at all levels. At the highest levels of governance and management there needs to be a national focus, a co-ordinating and sharing point, for activities aimed at promoting healthy workplace environments. Obtaining organisation-wide buy-in through engagement between management and staff is at the heart of developing a healthy environment. Keeping staff informed of what is occurring in the workplace, even if they are not directly involved, is very important. Effective human resource policies built on trust work to build institutional loyalty. Staff must understand the accountability structures and the consequences of their performance. It is important that organisations have in place structures that will support both decision-makers and those affected by the decisions.

Future initiatives to improve workplace environments, such as magnet hospitals, must be broadened to include not only hospitals but other work environments, for example, primary health care and mental health services. This will be an area of active growth and development and one of ongoing interest and involvement for HWAC.
To progress the development of healthy workplace environments, HWAC recommends that:

2.1 HWAC:

2.1.1 in consultation with the Ministry of Health, DHBNZ and professional bodies develops a set of national guidelines for implementation and monitoring of healthy workplace environments by June 2005

2.1.2 establishes reference groups with expertise in medicine, nursing and allied health to progress these recommendations and address other issues within HWAC’s Terms of Reference

2.2 DHBs:

2.2.1 develop and include action plans for healthy workplace environments in their workforce development plans for 2005/2006 to ensure:

• facilitation of staff involvement in decision-making
• effective and credible processes for decision-making
• implementation and evaluation of initiatives and structures to foster an effective and supportive workplace culture
• effective communication and information collection so that DHBs understand their workplace and staffing needs
• development of staff throughout their employment, including management development, where appropriate to their roles
• that staff have access to health management training, where appropriate to their roles
• that staff are able to include research competencies in their personal development plans, where appropriate to their roles
• an efficient, well-designed physical workplace environment

2.2.2 ensure action plans for healthy workplace environments are applied through every area of the organisation

2.2.3 review the implementation of their healthy workplace environment action plans by June 2006

2.2.4 explicitly prioritise and invest in the development of healthy workplace environments, with a view to enhancing recruitment and retention

2.3 the Ministry of Health:

2.3.1 identifies and supports leaders to foster the development of healthy workplace environments

2.3.2 monitors DHBs’ implementation of workforce development, including healthy workplace environments.
3. To facilitate the evolution and further development of health workforce education

In 2002 the Government released its tertiary education strategy. In general terms this aligns well with the Government’s Health and Disability Strategies. Implementation is the problem.

A culture of health and education integration in which professionalism is able to flourish is important. All governance mechanisms, performance management, contracting and monitoring, and funding mechanisms should ensure District Health Boards, the health sector and education organisations work towards improved integration.

A national framework is needed to identify issues and responsibilities in relation to health and disability workforce education. Competencies, scopes of practice, collaborative research and accessible education programmes are key issues. The historical anomalies in the funding of postgraduate education between the various health and disability practitioner groups are an ongoing issue that needs to be addressed. Concerns were raised by many groups throughout the consultation process that programme development and funding by the CTA should be more explicitly aligned with, and responsive to, health sector development.

The summit proposed that there be an assessment of the appropriateness of the current structures in educational institutions. Traditionally teaching hospitals have been the focus of and have determined the nature of health workforce education. DHBs have a crucial role to ensure that education and training is delivered in wider environments to meet the future health needs of New Zealanders. Community and clinical placements for trainees must be co-ordinated and shortages of places must be addressed. Flexible delivery methods would also improve access to and strengthen work-based learning.

The role of District Health Boards as educators needs to be strengthened. Teaching is part of being a professional and needs to be reflected in job descriptions and/or contracts. The teaching capability of staff needs to be enhanced and supported. The education sector needs to ensure it is, and remains, responsive to changes in health and disability workforce requirements. Mechanisms must be put in place to ensure the relevance of courses and diversity of students entering programmes for the health workforce.

Under the HPCA Bill the concept of scopes of practice is broadened to apply to all registered practitioners. The implications for health and disability practitioners require clarification and direction in relation to their educational preparation. HWAC sees one of its major tasks as trying to ensure that health and education sector interest groups communicate and work more closely and effectively together.
To facilitate the evolution and further development of health workforce education, HWAC recommends that:

3.1 the Ministry of Health, in collaboration with HWAC and DHBs:
   3.1.1 reviews the strategic framework around the CTA funding role in health workforce training by June 2005
   3.1.2 reviews the appropriateness of current postgraduate education frameworks and vocational training in order to meet the future workforce requirements and health needs of New Zealanders by June 2005
   3.1.3 works with TEC to ensure that health education courses meet the needs of the health and disability sector

3.2 DHBs and other health service providers acknowledge and support their role as educators in collaboration with education providers and professional bodies as provided for in their workforce development plans by June 2005

3.3 DHBs, through DHBNZ, and in collaboration with the Ministries of Health and Education, HWAC, and education providers, review by June 2005:
   3.3.1 their responsibility for, and role in, undergraduate medical and nursing education
   3.3.2 the appropriateness of current governance, administrative, financial and staffing arrangements for future development of these courses

3.4 the TEC and tertiary education organisations (TEOs), in collaboration with the health and disability sector, introduce mechanisms to ensure that:
   3.4.1 collaborative planning, information sharing and teaching between the health sector and tertiary education providers is strengthened
   3.4.2 wherever possible, delivery of educational programmes is made flexible to improve access
   3.4.3 health workforce education is responsive to changes in required skills for the diverse range of health practitioners
   3.4.4 health undergraduate education courses are responsive to the needs of the health and disability sector and strengthen competencies that contribute to teamwork, primary health care and culturally safe methods of practice
   3.4.5 students and graduates are actively recruited to better represent the diversity of the New Zealand population using broad selection criteria

3.5 TEOs, in consultation with the health and disability sector, introduce mechanisms to ensure that:
   3.5.1 the teaching capability of staff, both academic and clinical, is supported and strengthened
   3.5.2 clinical and community placements are better co-ordinated and aligned to the New Zealand Health Strategy and the New Zealand Disability Strategy.
4. To progress Māori health workforce development

The key message from the health and disability sector on Māori health workforce development is that Māori want action and change, and to create a sense of direction, purpose and unity. Māori need to be represented in the health workforce in proportion to the wider Māori population and equitably distributed across all occupational categories.

Māori would like to participate in the change and want a national Māori health workforce development function that will ensure a focus on both the Māori health and disability workforce and mainstream health sector responsiveness to Māori. The Treaty of Waitangi principles of partnership, participation and protection should be promoted to achieve collaborative service delivery and governance. Māori networks are rich resources and the proposed Māori health workforce development function should work from the principles around empowerment to hapū and iwi, power sharing, kotahitanga, leadership, mobilisation and implementation.

District Health Boards’ involvement in progressing Māori workforce development is seen as very important. DHBs have a key role in actively training Māori staff as well as recruiting well-qualified Māori staff. Effective collaboration between the health and education sectors is essential to achieving this goal. Educational and training programmes, ongoing education development for Māori health practitioners, and second-chance health education initiatives must be considered to meet the needs of the Māori workforce and the health needs of the Māori population. Staircasing and career development need to be introduced to broaden and increase the participation of Māori in the health workforce.

Much of this work is already under way in Māori mental health through Te Rau Puawai and Te Rau Matatini (Māori mental health workforce development). This work may serve as a model for Māori workforce development in areas other than mental health.

To progress Māori health workforce development, HWAC recommends that:

4.1 the Minister of Health establishes a national Māori Health Workforce Development function in the form of a specialist advisory group to HWAC

4.2 DHBs:

4.2.1 include requirements for increasing the capacity of the Māori workforce in their workforce development plans for 2004/2005

4.2.2 develop ‘Māori preferred-employer criteria’

4.2.3 provide ongoing education and development for existing Māori health practitioners

4.2.4 consider second-chance health education initiatives, including work experience and internships for Māori

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4 This concept is an adaptation of the ‘magnet hospital’ concept, which looks at what conditions are attractive to nurses. For a description of ‘Māori preferred-employer criteria’ see chapter 4 of Health Workforce Advisory Committee. 2002. The New Zealand Health Workforce: Framing Future Directions Discussion Document. Wellington: Health Workforce Advisory Committee.
4.3 the Ministry of Health collaborates with HWAC, the specialist advisory group, the TEC and health education providers to undertake a review of how current foundation, tertiary education and other clinical training programmes contribute to the development of the Māori health and disability workforce

4.4 the Ministry of Education, in collaboration with the Ministry of Health and DHBs, ensures:

4.4.1 accessible, positive health career guidance is provided throughout all levels of secondary schools for Māori students

4.4.2 development and resourcing of a marketing strategy to promote health and science as career options for Māori

4.4.3 development of outcome-based incentives for tertiary institutions providing health and disability education to increase Māori recruitment and course completion.

5. To progress Pacific health workforce development

The March 2003 summit emphasised the need for collaboration between the Ministries of Health and Education on Pacific workforce development. The participation of and collaboration with Pacific leaders in the health and disability sector and the community will be required in developing strategies to make progress in this area.

Successfully growing the capacity of the Pacific health workforce will require both a short- and a long-term focus. Ethnic-specific approaches to health, such as the concept of ‘for Pacific by Pacific’, need to be recognised and designed for deployment within mainstream health services.

The delivery of education guidance services at both secondary and tertiary levels is crucial. Feedback to HWAC indicates that the quality of advice to Pacific students on careers in health must improve. Active promotion by secondary schools of health as a career and demonstration that health is valuable from an individual, family and community perspective is needed. Initiatives are required to enable continuous learning and re-entry to the Pacific health workforce by health practitioners.

A multi-level approach is proposed, encompassing schools, the sector, and a wide range of health practitioners and education providers. Central to this approach is the development of career pathways, opportunities for ongoing learning, and targeted investment. There will need to be adequate intersectoral resourcing and ownership of these recommendations to achieve the specified goals.

To progress Pacific health workforce development, HWAC recommends that:

5.1 DHBs:

5.1.1 develop the capacity and capability of Pacific providers and their Pacific health and disability workforce

5.1.2 develop links and the sharing of resources between Pacific and mainstream providers

5.1.3 further develop organisational tools to address individual and institutional discrimination
5.2 the Ministry of Health collaborates with the DHBs, Ministry of Pacific Island Affairs, Ministry of Education, and other stakeholders as appropriate, to increase representation of Pacific peoples employed in DHBs through:

5.2.1 analysis of barriers and wider determinants of Pacific representation in the health and disability workforce
5.2.2 targeted investment and incentives
5.2.3 the development of sustainable career pathways to facilitate transition into health education
5.2.4 involvement of the Pacific health sector and community leaders to develop and implement strategies for Pacific health workforce development
5.2.5 identification and reduction of barriers to lifelong career development
5.2.6 measurement of progress by June 2005

5.3 the Ministry of Education, in collaboration with the Ministry of Health, ensures:

5.3.1 accessible, positive health career guidance is given throughout all levels of secondary school for Pacific students
5.3.2 the philosophies underpinning teaching and assessment methods are responsive to the learning needs of Pacific people
5.3.3 personal development, mentoring support and guidance for Pacific peoples during health education and training.

6. To facilitate evolution and development of the health and support workforce to better meet the needs of disabled people

HWAC has identified as one of its top priorities the strengthening of the support workforce meeting the needs of disabled people, many of whom are untrained, employed casually, and poorly supervised and remunerated. Despite this, the work they do is of the utmost importance in enabling people with continuing impairment – including the physical, sensory, intellectual and psychiatric impairment, and older people with chronic illness – to live positive and independent lives in the community.

Both the sector and the committee believe it is time to move beyond the identification of issues and towards taking specific actions. Identifying ways to progress the issues and solutions, and a keeper or steward of the decisions made, is required. Workshops with the sector facilitated by the committee would help achieve this.

The health and support workforce meeting the needs of disabled people is often devalued because disabled people are often devalued. HWAC is committed to seeing a marked improvement in arrangements for this workforce. It believes developing mechanisms for targeting investment in community-based workforce development will help address health and support workforce issues including isolation, dignity, and recruitment and retention. Differences in perspective, siloed funding, fragmented services, and narrowly defined and frequently proclaimed sectional and organisational self-interest, have historically frustrated and delayed much needed action in this area. It is important that the health and support workforce is valued, both for who they are and what they can contribute.
Failure to meet the reasonable training needs of the support workforce could have far-reaching implications, in both human and financial terms. Disabled people with inadequate support living in the community may eventually make a greater call, at greater cost, on overstretched and expensive hospital and other residential facilities. It is therefore false economy not to provide ongoing support for people with disability and the support workforce.

People experiencing disability have told HWAC that they will no longer be the passive recipients of services. They and, where appropriate, their family supporters want to be active partners as both recipients and as service providers.

Developing career pathways to enable people experiencing disability to participate in the health and support workforce is required. This means promoting working in the disability sector as a career option. Specialised training to work with disabled people should be incorporated into the mainstream with the trainers themselves being disabled or experienced with disability services.

Collaboration with disabled people and their families will offer a real opportunity to develop new models of providing support and for disabled people and their families to be more involved in delivering services. Building the capability and capacity of the support workforce in the disability sector is integral to delivering health and disability services to all New Zealanders including people with disabilities.

To facilitate evolution and development of the health and support workforce to better meet the needs of disabled people, HWAC recommends that:

6.1 the Ministry of Health, in partnership with DHBs, the Office for Disability Issues, health and education service providers and disabled people, works to:
   6.1.1 develop a programme of activities to enhance health practitioners’ knowledge of, and responsiveness to, disability issues
   6.1.2 resource inclusion of people experiencing disability and, where appropriate, members of the families of disabled people, in the training of health practitioners
6.2 DHBs and disabled people investigate incorporating a disability advisory role in primary care environments
6.3 the Ministry of Health, in partnership with HWAC and the Office for Disability Issues, holds a workshop or a series of workshops with key disability sector stakeholders to:
   6.3.1 develop an agreed way of identifying the support workforce issues for disabled people
   6.3.2 progress the solutions to identified disability workforce issues
   6.3.3 agree a lead agency to oversee this development
6.4 the lead agency, in partnership with disabled people and key stakeholders, works to investigate the capacity and capability of the workforce to meet the aspirations of disabled people as outlined in the New Zealand Disability Strategy.
7. To facilitate the enhancement of health workforce research and evaluation capability

The importance of health workforce research as a basis for sound decision-making was a recurring theme during the consultation process and in the committee’s deliberations. Internationally, there is an increasing interest in considering new ways for practitioners to work effectively within a rapidly changing environment.

Workforce development is an underdeveloped area of health services research. Most such research is directed at the application of technologies or the use of pharmaceuticals and other treatment devices. The knowledge and skills that trained and experienced health practitioners bring to care are typically overlooked by researchers. What research is done is usually carried out by researchers based in academic settings, is externally funded, and is often done on the providers and users of services rather than with them.

Research is sometimes described as ‘organised curiosity’. It is characterised by a systematic approach to the asking and answering of questions. As part of their training all health practitioners should be exposed to the key roles that information, research and evaluation can play in their practice.

Research and evaluation can and should play a significant role in innovation and in driving local health service and workforce development efforts. These benefits have already been described (HWAC 2002b). Again, what is proposed here is a significant culture change. Research and evaluation are necessary to encourage and take advantage of innovation and to initiate and guide service and workforce redesign and improvement. Research in these terms should be seen as a core organisational function such as business planning, financial planning, IT development, and human resource management. It should not be marginalised.

Forums to discuss local research and evaluation projects should be used to publicise and share information, and to promote safety, quality, service and workforce improvement. Research and evaluation expertise should be developed further and resources targeted specifically to achieve these ends. HWAC would like to see a number of demonstration projects mounted that are firmly grounded in this action research and development approach. The Health Research Council (HRC) could have an important facilitative role in these initiatives.

To facilitate the enhancement of health workforce research and evaluation capability, HWAC recommends that:

7.1 the Ministry of Health, in consultation with DHBNZ, HWAC, HRC and professional bodies, develops a national health and disability workforce research framework by June 2005

7.2 the Ministry of Health and DHBs collaborate to:

7.2.1 actively share evaluated health and support workforce best practice
7.2.2 resource research on and evaluation of innovation around healthy workplace environments
7.2.3 progress the current work on a comprehensive health workforce information system
7.3 the Ministry of Health identifies funding resources for applied research in primary health care workforce development

7.4 the Ministry of Health, HRC and DHBs collaborate with the TEC and health education providers to:
   7.4.1 further develop research on the Māori health and disability workforce and integrate it into mainstream organisational behaviour and clinical practice
   7.4.2 commission research about culturally effective, ethnic-specific and pan-Pacific models of care and integrate this into local mainstream organisational behaviour and clinical practice

7.5 DHBs produce local research and development plans for their health and disability workforce consistent with the national health and disability workforce research framework

7.6 the TEC and the Ministry of Health consult with the health and disability sector when implementing Performance-based Research Funding to ensure research capability is strengthened and more clearly aligned with health service practice.

Key recommendations for early implementation

Implementation of all recommendations will take time as individual DHBs will have their own priorities and may already be taking action on some of these issues. Therefore, HWAC has identified eight key recommendations\(^5\) for early implementation.

HWAC recommends that:

1.1 to address the health workforce implications of the Primary Health Care Strategy the Ministry of Health:
   1.1.1 requires DHBs to include the primary health care workforce in their workforce development plans by June 2005
   1.1.2 promotes and appropriately resources collaborative workforce practice within the health and disability sector to achieve the goals of the Primary Health Care Strategy

2.1 to progress the development of healthy workplace environments HWAC, in consultation with the Ministry of Health, DHBNZ and professional bodies, develops a set of national guidelines for implementation and monitoring of healthy workplace environments by June 2005

3.1 to facilitate the evolution and further development of health workforce education the Ministry of Health, in collaboration with HWAC and DHBs:
   3.1.1 reviews the strategic framework around the CTA funding role in health workforce training by June 2005
   3.1.2 reviews the appropriateness of current postgraduate education frameworks and vocational training in order to meet the future workforce requirements and health needs of New Zealanders by 2005
   3.1.3 works with TEC to ensure that health education courses meet the needs of the health and disability sector

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\(^5\) The numbering of this subset of key recommendations is consistent with the full set of recommendations outlined in the document.
4.1 to progress Māori health workforce development the Minister of Health establishes a national Māori health workforce development function in the form of a specialist advisory group to HWAC

4.2 to progress Māori health workforce development DHBs include requirements for increasing the capacity of the Māori workforce in their workforce development plans for 2004/2005

5.1 to progress Pacific health workforce development DHBs develop the capacity and capability of Pacific providers and their Pacific health workforce

6.1 to facilitate evolution and development of the health and support workforce to better meet the needs of disabled people the Ministry of Health, in partnership with DHBs, the Office for Disability Issues, health and education service providers and disabled people, works to develop a programme of activities to enhance health practitioners’ knowledge of, and responsiveness to, disability issues

7.1 to facilitate the enhancement of health workforce research and evaluation capability the Ministry of Health, in consultation with DHBNZ, HWAC, HRC and professional bodies, develops a national health and disability workforce research framework by June 2005.
Implementation of the Government’s Health and Disability Strategies requires some fundamental rethinking about the culture of the sector – the way the sector behaves and does its business – and about the design and structure of both the services and the workforce. Simply doing more of the same is not an option.

New arrangements are needed to enable health consumers and the public to actively engage with the politicians, policy-makers, planners, purchasers and providers of services including public, private and NGO providers. The emphasis must shift from designing for local people – the local users and providers of services – to designing with them.

The challenge to the health sector is to continue to work in partnership to implement these recommendations. Past differences and divisions in the workforce must be put aside in favour of more co-operative and collaborative working arrangements. Networking, partnerships and teamwork must become the order of the day. By working together there is likely to be a greater degree of agreement with and ownership of the policy direction taken. This will help ensure that the vision outlined for the health sector in the New Zealand Health and Disability Strategies is realised.

New balances will have to be achieved between the differing world views held by sections of the health workforce – the biomedical views of medical practitioners, the economic and managerial views of administrators, and the social and culture-specific views held by nurses, midwives, Māori, Pacific peoples, support workers and user and community groups. Processes of sustainable dialogue must be created that enable such differences to be voiced, listened to, explored and accepted as legitimate and valued contributions to health sector development.

It is too much to expect the desired behavioural changes and working arrangements to occur overnight. In human systems as complex as health, only evolved change is likely to be sustainable. Horizontal, networked and co-operative approaches are more likely to succeed than vertical, hierarchical mechanisms.

The education and training of all health practitioners must equip them to work in this new and constantly changing environment. This will require not only curricula changes but also changes to teaching and learning processes, with more emphasis on interdisciplinary and team teaching and learning, and on teaching and learning in the workplace and particularly in community settings.

Crucial to the issue of educating a responsive workforce is the need for alignment and co-ordination between the health and education sectors. HWAC’s summit demonstrated a strong willingness by the sector to work on this intersectoral engagement and ensure that relationships between the health and education sectors at all levels are strengthened for the benefit of health workers and their clients. HWAC will take an active role in the facilitation and monitoring of these relationships as the TEC progresses its work programme.

Addressing the issues of diversity, increasing the participation of Māori and Pacific peoples in the workforce, and ensuring the development of the health and disability workforce will be an active part of the committee’s work programme, in collaboration with other stakeholders in this area.
HWAC’s recommendations are intended to provide a broad, strategic systems framework for current workforce challenges. The need to focus also on a number of specific areas of concern, such as improving workforce information, the adequacy of the medical, nursing and public health workforce, and mental health workforce issues is acknowledged. These will be considered in future work programmes. It is important to note that there is a wealth of data available and work already under way in these areas, which will provide a strong base for informed discussion and further recommendations.

The way forward requires a major culture or paradigm shift in the sector so that thinking and actions support a whole health system that works with communities in ways that benefit the whole population. The Committee does not support and is not recommending further radical or disruptive change. Rather it is recommending a strategically guided process of evolving change that enables the health sector and its workforce to constantly adapt to what is and will continue to be a challenging, exciting and ever-changing health sector environment.
## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td><strong>Allied health</strong></td>
<td>An area of health, such as pharmacy, physiotherapy and occupational therapy, most often based in the community, that does not include doctors and nurses.</td>
</tr>
<tr>
<td><strong>Applied research</strong></td>
<td>Grounded, real world research, including action research conducted using a range of sound qualitative and quantitative methodologies.</td>
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<tr>
<td><strong>Broad selection criteria</strong></td>
<td>The process of selecting candidates based on what they are able to bring with them and contribute, such as life and communication skills, their values and cultural strengths.</td>
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<tr>
<td><strong>Community</strong></td>
<td>A collective of people identified by their common values and mutual concern for the development and wellbeing of their group or geographical area.</td>
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<tr>
<td><strong>Community-based health</strong></td>
<td>Health services delivered in the community.</td>
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<tr>
<td><strong>Competencies</strong></td>
<td>The attitudes, skills, knowledge and behaviour held by health practitioners and support workers to perform particular functions.</td>
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<tr>
<td><strong>Continuity of care</strong></td>
<td>People are able to access needed services at the right time, in the right place and from the right people.</td>
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<tr>
<td><strong>Cultural safety</strong></td>
<td>An approach in which health practitioners are knowledgeable of, and sensitive to, the specific cultural needs of the people and populations they serve.</td>
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<tr>
<td><strong>Culturally appropriate services</strong></td>
<td>Services responsive to, and respectful of, the history, traditions and cultural values of the different ethnic groups in our society.</td>
</tr>
<tr>
<td><strong>District Health Boards (DHBs)</strong></td>
<td>District Health Boards are funders and providers of publicly funded services of a specific geographic area. Twenty-one DHBs were established under the New Zealand Public Health and Disability Act 2000.</td>
</tr>
<tr>
<td><strong>District Health Boards New Zealand (DHBNZ)</strong></td>
<td>An organisation that represents all DHBs.</td>
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<tr>
<td><strong>Evolutionary approach</strong></td>
<td>An approach in which systems changes are planned and incremental rather than forced and sudden.</td>
</tr>
<tr>
<td><strong>Globalisation</strong></td>
<td>Process by which the domestic and international labour markets have become interconnected and allow the free movement of health practitioners between countries.</td>
</tr>
<tr>
<td>Governance</td>
<td>The system for strategic leadership. This includes systems for decision-making and the gathering and distribution of information relevant to decision-making.</td>
</tr>
<tr>
<td>Health Practitioners Competence Assurance (HPCA) Bill</td>
<td>Proposed legislation designed to protect the health and safety of the New Zealand public by ensuring that health practitioners are competent and fit to practice within their scope of practice.</td>
</tr>
<tr>
<td>Integrated health service delivery</td>
<td>An integrated approach to health and disability support services that is responsive to people’s varied and changing needs. Providers co-ordinate their services, working closely with the person and, where appropriate, with their family, whānau and carers to provide services that appear seamless to recipients. For Māori operating within a framework of whānau ora, this means placing the whānau at the centre of health care and support for Māori.</td>
</tr>
<tr>
<td>Interdisciplinary</td>
<td>An approach in which individuals from two or more professions work collaboratively to improve health outcomes. The approach emphasises the connectivity, alignment and collaboration between primary, secondary and tertiary health care services.</td>
</tr>
<tr>
<td>Intersectoral collaboration</td>
<td>Projects involving various sectors of society including central and local government agencies, community organisations and the private sector.</td>
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<tr>
<td>Kotahitanga</td>
<td>Unity/oneness – working together to achieve the same aim.</td>
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<tr>
<td>Magnet hospitals</td>
<td>A set of hospitals that were studied in the 1980s and 1990s because they were effective in attracting and retaining staff. Comprehensive analysis of these hospitals was made initially in the US, and later in other countries (Aiken L, Smith H, Lake E. 1994).</td>
</tr>
<tr>
<td>Māori preferred-employer criteria</td>
<td>This concept is similar to work done on ‘magnet hospitals’ (see above).</td>
</tr>
<tr>
<td>Models of care</td>
<td>An approach for developing service delivery around particular patient needs (eg, developing service components required by individuals with diabetes).</td>
</tr>
<tr>
<td>New Zealand Disability Strategy</td>
<td>A strategy that aims to change New Zealand from a disabling society to one that is inclusive of disabled people, defined as ‘a society that highly values our lives and continually enhances our full participation’.</td>
</tr>
<tr>
<td>New Zealand Health Strategy</td>
<td>An overall framework for the health sector, with the aim of directing health services at those areas that will ensure the greatest benefits for our population, focusing in particular on tackling inequalities in health.</td>
</tr>
<tr>
<td>Non-government organisations (NGOs)</td>
<td>Encompasses community or voluntary organisations; Māori, iwi and hapū organisations; and for-profit organisations where government organisations contract with them for delivery of outputs.</td>
</tr>
<tr>
<td>Nurse practitioners</td>
<td>Experts in their field who use advanced knowledge and skills within their specialist scope of practice. Nurse practitioners are educated through a clinically focused master's degree programme and must meet the competencies set out by the Nursing Council. These include being able to articulate and advance the scope of their nursing practice, showing expert practice and working collaboratively with other disciplines as well as across settings. Competencies also include demonstration of leadership and consultancy in nursing, active development and influence on policy and nursing practice. Nurse practitioners may or may not choose to be nurse prescribers. 6</td>
</tr>
<tr>
<td>Office for Disability Issues</td>
<td>Positioned within the Ministry of Social Development, the office's role is to lead, monitor and promote the New Zealand Disability Strategy and provide policy advice on disability issues.</td>
</tr>
<tr>
<td>Pacific peoples</td>
<td>People from Pacific countries or ethnic backgrounds (Samoan, Cook Island Māori, Tongan, Niuean, Fijian and Tokelauan) who are resident in New Zealand.</td>
</tr>
<tr>
<td>Pan-Pacific</td>
<td>Inclusive of all Pacific peoples.</td>
</tr>
<tr>
<td>Population health</td>
<td>The health of groups, families and communities. Population may be defined by locality, biological criteria such as age or gender, social criteria, such as socioeconomic status, or cultural criteria such as whānau.</td>
</tr>
<tr>
<td>Primary health care</td>
<td>Essential health care based on practical, scientifically sound, culturally appropriate and socially acceptable methods. It is universally accessible to people in their communities, involves community participation, is integral to, and a central function of, the country’s health system, and is the first level of contact with the health system.</td>
</tr>
<tr>
<td>Primary Health Organisations (PHOs)</td>
<td>Local not-for-profit provider organisations funded by DHBs to provide primary health care services for an enrolled population.</td>
</tr>
<tr>
<td>Professional colleges</td>
<td>Organisations authorised to register vocationally qualified medical practitioners.</td>
</tr>
<tr>
<td>Scopes of practice</td>
<td>Health services that a practitioner is qualified and competent to offer, the parameters within which these services can be offered and a time period for review.</td>
</tr>
</tbody>
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6 Nursing Council of New Zealand, 2001
Silo  
A separate or isolated system.

Staircasing  
The ability for health workers to move systematically along a career pathway with recognition of prior learning.

Support workforce  
Workers who provide general and personal support to assist people to maintain independence and participate in society (eg, mental health support workers, vocational support workers, older people support workers and health care assistants). This does not include kitchen workers or other hospital or administration support staff.

Te reo Māori  
Māori language.

Tertiary Education Commission (TEC)  

Tertiary institutions or tertiary education organisations  
Organisations such as polytechnics or universities that provide post-secondary school education.

Workforce development  
Any initiative that influences entry to and exit from the health and disability sectors, education, training, skills, attitudes, rewards and the associated infrastructure.
Appendix 1: 
Health Workforce Advisory Committee

Back row: George Salmond, Ian Wilson, Clive Ross, Colin Mantell, Ralph Wiles, Mike Gourley
Front row: Jane Lawless, Andrew Hornblow (Chair), Karen Guilliland (Deputy Chair) Insert: Margaret Southwick

Professor Andrew Hornblow, CNZM (Chair)
Professor Hornblow is a psychologist, and is former Dean of the Christchurch School of Medicine and Health Sciences, University of Otago. He is currently also Chair of the Alcohol Advisory Council. He has served on the Health Research Council and the Public Health Commission, was Foundation President of the NZ Public Health Association, is a former Chairman of the Mental Health Foundation, and a past President of the New Zealand Psychological Society.

Karen Guilliland, MNZM (Deputy Chair)
Karen Guilliland is a midwife and is currently the CEO of the New Zealand College of Midwives. She is a Board member of PHARMAC and a member of the Minister of Health’s Health Advisory Group. She is a former member of the Canterbury Area Health Board and the New Zealand Nursing Council.
Dr Ralph Wiles
Ralph Wiles is a general practitioner practising in Tokoroa. The practice has a high number of Māori and Pacific patients. Ralph is the immediate past Chairperson of the Royal New Zealand College of General Practitioners.

Dr Clive Ross, CNZM
Clive Ross is a dental practitioner in Auckland, and is also registered as a specialist in restorative dentistry. Clive actively participates in the World Dental Federation, which represents dental associations and individual dentists worldwide. He is also a member of the World Health Expert Advisory Committee, and he chaired the joint WHO/World Dental Federation study on workforce methodology. He is a past Chairman of the Dental Council of New Zealand.

Professor Colin Mantell
Colin Mantell is Professor of Māori and Pacific Health and Head of the Māori and Pacific Health Department at the University of Auckland. He is a Professor of Obstetrics and Gynaecology at the National Women’s Hospital and has held head of department posts at the National Women’s Hospital and Middlemore Hospital in South Auckland. Colin is a past member of the Health Research Council of New Zealand and a member of the Māori Health Research Committee. Colin’s iwi affiliation is Ngai Tahu.

Mr Mike Gourley
Mike Gourley has been self-employed since 1995 working on contract to National Radio and Long White Cloud Productions. He has been employed by the Wellington College of Education as a lecturer in Disability Studies, and is a member of the New Zealand Disability Strategy Sector Reference Group.

Dr George Salmond
George Salmond is a consultant, who has been involved in research activities related to the health workforce and health services over a number of years. He was Director-General of Health from 1986 to 1991.

Ms Jane Lawless
Jane Lawless is a staff nurse at Waikato Hospital, and Chairperson of the College of Emergency Nurses New Zealand (New Zealand Nurses Organisation).

Dr Margaret Southwick
Margaret Southwick is the Head of School, Pacific Health Education and Research, Whitireia Community Polytechnic. She is also a member of the Nursing Council of New Zealand and a peer review panel member of the health panel for the Performance-based Research Fund.

Mr Ian Wilson
Ian Wilson is an experienced Company Director and is the Chair of MidCentral District Health Board and the Institute of Environmental Sciences and Research Limited. He is also a director of a number of other private and public companies.
Appendix 2:
Workplace environments: negative and positive performance spirals

Figure 1: Workplace environment: negative performance spiral

**Performance Problems**
- negative reputation as employer and provider of care
- lower quality of patient care (e.g., mortality, post-operative infection)
- increased costs (e.g., recruitment, casual labour)
- labour shortages
- high turnover affecting continuity of care, programme development, institutional knowledge and mentoring

**Individual Behaviours**
- reduced focus on work and less productivity
- burnout, lateness and absenteeism
- higher staff turnover
- more accidents
- vertical and horizontal conflict (e.g., bullying, distrust between clinicians and managers)
- reduced loyalty and ‘ownership’ of organisational development

**Organisational Response**
- reduce training and staff development
- management ‘control’ model
- salary freeze
- use of casual labour
- freeze on hiring or promotion

Source: Adapted from Norman 1999; Becker and Huselid 1998.
Figure 2: Workplace environment: positive performance spiral

**Good Organisational Practice**
- participatory decision-making
- culture promotes teamwork, support, communication, innovation, inclusion, clinical effectiveness and risk management
- excellent change management
- systematic collection of information to understand, develop and monitor workplaces
- excellent staff orientation, training and ongoing development
- workloads, remuneration and skill mixes are optimally structured
- clinicians make timely decisions based on expert judgement

**Performance Results**
- higher quality of care
- staff retention
- reduction in costs
- reputation of hospital

**Individual Behaviours**
- satisfaction or good morale
- optimal stress levels
- low levels of absenteeism, lateness and stress-related illnesses
- high levels of motivation
- loyalty and enthusiasm about the organisation and the results being achieved
- constructive working relationships between staff, including goodwill

Source: Adapted from Norman 1999; Becker and Huselid 1998.

Appendix 3: A model for workforce development

A Model for Workforce Development

Prerequisites
- national health goals and strategies
- health sector commitment to workforce development
- health and education sectors working together
- national and regional workforce databases

Goals
- an appropriately skilled, supported, and responsive workforce to achieve optimum health care, improved health outcomes

Workforce development strategies
- strengthen primary care workforce and skill base
- promote healthy workplace environments
- educate for scopes of practice, teamwork, lifelong learning, etc
- attract and support a balanced workforce
- recognise and develop support workers

Workforce management tools
- policy
- communication
- remuneration
- incentives
- training
- etc


