

---

# **HEALTH WORKFORCE ADVISORY BOARD**

## **Annual Report to the Minister of Health**

### **November 2020**

---

## Contents

1.	Introduction .....	3
2.	Board scope in 2019/2020 .....	4
3.	Planning for New Zealand’s health and disability system workforce .....	5
3.1.	Transition support.....	5
3.2.	Health workforce funding .....	5
3.3.	The public health workforce .....	6
3.3.	Data, analysis and research .....	7
3.3.1.	Invisibility of non-regulated workforce .....	7
3.3.2.	Value of the health workforce.....	8
4.	Enabling greater participation of Māori in the health workforce and partnering with Māori to better understand the needs and aspirations of the Māori workforce .....	9
4.1.	Māori health workforce crisis .....	9
5.	Enabling greater participation of Pacific and other under-represented populations in the health workforce.....	12
5.1.	Pacific .....	12
5.2.	Disabled people .....	13
5.3.	Non-regulated workforce representation .....	13
6.	Education, training and development of the health workforce .....	14
6.1.	Workforce flexibility.....	14
7.	Recruitment, retention and distribution of the health workforce .....	16
7.2.	COVID-19.....	17
7.2.1.	COVID-19 change examples.....	17
8.	Health workforce wellbeing .....	18
9.	Supporting quality improvement, innovation and changed ways of working.....	19
9.1.	Telehealth .....	19
10.	Conclusion.....	21
	Membership of the Health Workforce Advisory Board .....	22

## **1. Introduction**

This is the first Annual Report to the Minister of Health by the Health Workforce Advisory Board which was introduced in 2019 under section 11 of the New Zealand Public Health and Disability Act 2000.

The Board was established to provide advice to the Minister on health workforce matters including strategic direction, emerging issues and risks. Under section 15 of the Act, the Board must report to the Minister at least once a year in relation to its statutory purpose. A copy of the report will be presented to the House of Representatives by the Minister.

The Board works with the Ministry of Health, in particular alongside the Health Workforce Directorate, to provide strategic oversight and sector leadership for New Zealand's health workforce. It has a wide membership covering medical, clinical, nursing, pharmacy, health sector academics, strong Māori and Pacific representation and rural advocacy. Unlike the former Health Workforce New Zealand which focussed on the regulated professions, the Board does not have any personnel, funding or budget management responsibilities and is concerned with the whole of the health workforce, both regulated and unregulated.

The Board is not involved in health sector employment relations. However, there are current employment relations issues, including pay parity and pay equity, that significantly impact on the health workforce's scale, structure and culture. COVID-19 has amplified the importance of taking a holistic approach to these issues to avoid perpetuating inadvertent inequities of pay which may disadvantage one part of the workforce at the expense of another, and distorts recruitment and retention in say, primary care or the community not-for-profit sector.

The Board has a particular interest in supporting the Health Workforce Directorate take a whole of systems (i.e. not just District Health Boards (DHBs) and the Regulatory Authorities) approach to health sector workforce planning, developing leadership across the system and investing in the workforce outcomes New Zealand requires. This is in accordance with its Terms of Reference that state that the Board will work with the Ministry of Health to provide strategic oversight and sector leadership for New Zealand's health workforce.

The Health and Disability System Review was underway when the Board started its work and the first Annual Report references across to the Health and Disability System Review recommendations where appropriate. The Annual Report is provided under section 15 of the New Zealand Public Health and Disability Act 2000 and relates to its statutory functions. It is structured and presented against the Terms of Reference. These include that the Board will provide strategic oversight, advice and recommendations on matters relating to health workforce including but not limited to:

- (a) Planning for New Zealand's health and disability system workforce
- (b) Enabling greater participation of Māori in the health workforce and partnering with Māori to better understand the needs and aspirations of the Māori workforce
- (c) Enabling greater participation of Pacific and other under-represented populations in the health workforce
- (d) Education, training and development of the health workforce
- (e) Health workforce wellbeing
- (f) Supporting quality improvement, innovation and changed ways of working.

The Ministry's Health Workforce Directorate has strengthened capacity and capability in the past year through new leadership and recruitment of personnel. It has scoped a potential workforce

strategy that encompasses the pipeline and the attraction of people into health and disability careers through education, recruitment, retention and development.

The Directorate is building its reputation among the many, varied health workforce stakeholders including regulatory authorities, professional associations, unions and employers, DHBs, primary care groups and academic and policy communities. It is well positioned to provide critical input into the Ministry-led national health workforce plan with a 10-15 year horizon recommended by the Health and Disability System Review.

The first year of the Health Workforce Advisory Board's work coincided with the global COVID-19 pandemic which focussed public and social attention on the value we place on health workers as essential workers who were at the heart of the health and wellbeing response both in community testing facilities, quarantine and managed isolation, hospital care, aged care, primary care and the community. The value of health and care workers was not previously high in public consciousness. Acknowledging the indispensability of the health workforce went hand in hand with identifying both the strengths and weaknesses of the workforce we currently have and the challenges and opportunities for New Zealand to move in a more agile and purposeful direction to meet future health needs. The report references COVID-19 where relevant.

## **2. Board scope in 2019/2020**

Positive cooperation exists between the Board and the Directorate in relation to stakeholder engagement, expert opinion and advice from independent HWAB members to the Ministry, technical support when required, and the addressing of issues relating to workforce vulnerabilities. All of these have been a feature of the work to date in responding to the traditional dynamics of the health workforce as well COVID-19 related workforce issues.

Health workforce activities the HWAB has provided advice and support to the Directorate in 2019/20 include:

- Scoping the review of the current health workforce funding arrangements for the approximately \$200 million Ministry of Health workforce funding
- Developing a Māori health sector workforce strategy
- Advocating for the future development of a Pacific health workforce strategy including support for additional health science academies in secondary schools
- Supporting the Directorate-led COVID-19 surge workforce
- Policy to help improve representation of disabled people in the health workforce
- Commissioning of independent research on the value of the health workforce
- Supporting the Directorate-led procurement process for the nurse practitioner training programme
- Working with rural health stakeholders to ensure an agile COVID-19 response including immigration settings for essential workers
- Supporting increased funding for new Public Health Medicine Registrars in 2021
- Ensuring a whole of systems approach to health workforce matters including working with kaiāwhina representatives
- Identifying training, education and pipeline difficulties for health specialist and vulnerable workforces affected by COVID-19 and /or immigration settings.

### **3. Planning for New Zealand’s health and disability system workforce**

#### **3.1. Transition support**

The coronavirus pandemic is a watershed moment for the health sector adding to the political will and social momentum to reform existing services so that equity guides access and outcomes, emphasis is placed on prevention, and services are sustainable. New Zealand cannot waste the chance provided by the catalyst of COVID-19, and the shape and future of the health workforce is critical to both transition outlined in the Health and Disability System Review implementation and the radical transformation required of health services. Reimagining New Zealand’s future health service cannot rely on structural change and realignment alone. It must have at its heart – people-as patients, families and whānau, doctors and clinicians, allied health professionals, nurses, carers, and administrators. The Health Workforce Advisory Board believes the Health Workforce Directorate should be closely involved as a key stakeholder working collaboratively with the Transition Unit so that workforce issues are central to the successful implementation of reform outcomes, at a time when the future of healthcare is being reshaped by the pandemic.

#### **3.2. Health workforce funding**

Workforce development is a key constraint in New Zealand’s current health and disability system, according to the Health and Disability System Review. Health academics suggest that concerns over New Zealand’s health workforce sufficiency, distribution and sustainability continue despite numerous policy interventions over past decades. They also state that proposed solutions tend to focus on supplying medical professionals to meet predicted numbers or resolve distributional problems.<sup>1</sup>

It is clear that the Ministry’s current health workforce funding arrangements are a critical element of workforce development. Approximately 14,000 people currently benefit across the categories of medical, nursing, allied health, midwifery, mental health, disability, Māori, Pacific, rural health and the Voluntary Bonding Scheme. However, the investment model has remained largely unchanged since 2007.

This has prompted a review of the current health workforce funding arrangements by the Health Workforce Directorate with the support and direction of the Board to ensure that the commissioning of education and training are delivering the desired outcomes in time for the 2022 calendar year. With the implementation of the Health and Disability System Review recommendations, there is an opportunity to leverage the cross-sector education funding to influence the growth of health professionals that the system requires. It is imperative that the Transition Unit works with the Directorate and the Board to ensure the funding framework aligns with, and guides, the structural reforms for greater stewardship of the future health workforce.

**The Board requests that the Minister notes the review of current health workforce funding and that the Health and Disability System Review presents an opportunity for the Transition Unit and the Health Workforce Directorate to ensure workforce funding effectively influences the growth of the required future health workforce.**

---

<sup>1</sup> Rees,G.H., Crampton,P., Gauld,R., and MacDonell,S. (2018). “New Zealand’s health workforce planning should embrace complexity and uncertainty”. *New Zealand Medical Journal*, Vol 131, no 1477, pp 109-115.

### 3.3. The public health workforce

The global pandemic exposed in a number of jurisdictions including New Zealand the under-investment in public health infrastructure and in the numbers and scope of public health professionals. Before COVID-19 the College of Public Health Physicians was advocating for increased investment in public health as a proactive preventative approach and identified that the development of the public health workforce was urgently required.<sup>2</sup> In 2020 the Health Workforce Directorate responded to a call from the College for more support for Public Health registrar training placements and in 2021 five more will be funded.

The Health and Disability System Review, which strongly identified the need for a critical focus on population health, estimated the combined Ministry of Health and DHB spend on public health is equivalent to just two per cent of total DHB expenditure. The review report also said that the only increases to the Public Health Services Appropriation since 2010 had been for specific new services or initiatives.<sup>3</sup>

Funding of Public Health Units (PHUs) in DHBs across New Zealand had not kept pace with inflation, increases to Multi Employer Collective Agreements or population increases, impacting on staffing levels. Worryingly, the College states that the Public Health Medicine Specialist (PHMS) workforce has declined in the 2015-2018 period, the only medical speciality of more than 100 doctors to have slipped in the period. The College's projections show that unless urgent action is taken, the position could further deteriorate. COVID-19 interruptions to the number of international medical graduates entering the country and projected retirements of ageing specialists could also further impact on numbers.

PHMSs contribute significantly to health equity, improved child and youth wellbeing and mental health. The workforce is involved in health protection, climate change effects, safe drinking water, healthy food and drink and the delivery of screening programmes. Contemporary health issues such as the global pandemic, the Havelock North campylobacter outbreak, the 2019 measles epidemic, and the impact of obesity on health services highlight not only the need for more public health professionals, but also different specialities and skills. These include, for example, epidemiologists with statistical expertise, geospatial epidemiologists, public health expertise in social marketing and communications, infomatics and emergency management as well as related specialist areas such as occupational health and drinking water assessment.<sup>4</sup> In addition to public health expertise in universities, the Ministry and policy agencies, COVID-19 has graphically demonstrated the need for "front line" public health expertise that is culturally embedded within Māori and Pacific communities. Increasing the number of nurse practitioners and allied health consultants with a public health focus in community and rural settings are other required system improvements.

**It is recommended that ongoing investment in opportunities for public health medicine registrars be a funding priority and that public health medicine training be an area of significant focus in a review of health workforce funding.**

<sup>2</sup> New Zealand College of Public Health Medicine (2019) "The Case for Investing in Public Health" Infographic.

<sup>3</sup> Health and Disability System Review, 2020. *Health and Disability System Review- Final report- Purango Whakamutunga*. Wellington: HDSR. p.83.

<sup>4</sup> Dumble,F., Miller,J., Poynter,M., Shoemack,P. (2020) While we have your attention.... Editorial, *New Zealand Medical Journal*. 8 May Vol.133.No 1514, pp 7-8.

### 3.3. Data, analysis and research

Successful and efficient planning for New Zealand’s health and disability system requires comprehensive data and analytics for policy formation. The Ministry’s Health Workforce Directorate has unique and internationally acknowledged expertise in data modelling and analytics which has had a specific focus on the regulated workforce. But there are significant gaps in major areas of health sector data collection and analysis which require identification, prioritisation and action to address. The most significant of these relates to the absence of reliable workforce survey data on the non-regulated workforce. Another gap relates to the absence of statistical clarification and consistency of definition as to what constitutes “rural” impacting on policy and planning for the rural health workforce.<sup>5</sup>

#### 3.3.1. Invisibility of non-regulated workforce

New Zealand has relied primarily on regularly collected workforce survey data that is provided by Regulatory Authorities and professional organisations to forecast future numbers of particular professions. Quantitative predictive forecasting has been used for analysis that might inform policy choices in relation to the regulated health workforce. Limited or unreliable workforce data and intelligence affects whole of system analysis and New Zealand’s ability to understand the total workforce and the training investment required.

A critical omission from workforce data has been the absence of reliable information about the unregulated health workforce which could be of the scale of 110,000 plus people. For more than two decades report after report, including the Health and Disability System Review, has lamented the lack of reliable workforce data for the Kaiāwhina workforce. This has negatively impacted on the health system.

For example, the Ministry was unable to communicate directly with kaiāwhina during COVID-19 regarding expectations, risks and precautions. Nor could it estimate the total amount of Personal Protective Equipment (PPE) required, or where it was needed, effectively plan surge capacity through redeployment, or readily undertake contact tracing. Aged residential care and rest home responses to COVID-19 largely relied on kaiāwhina commitment and they were essential workers during the alert level system in the community for people with long term conditions and disabilities.<sup>6</sup>

In addition the manifest and symbolic value of kaiāwhina work remains marginalised and largely invisible unless it is quantified. The new Health, Community and Social Services Workforce Development Council, established by the reform of vocational education, will rely on accurate data on all sectors of the health and disability workforce. Stakeholder support for accurate workforce data is expected to be considerable. The Health and Disability System Review suggested that *“priority should be placed on gathering data in areas where less is known (e.g. non-regulated workforces and allied health). The Ministry is taking steps to improve data collection about the non-regulated workforce but it will take some time before this is sufficiently robust to use for long-term planning and modelling.”<sup>7</sup>*

---

<sup>5</sup> Nixon, G. (2020). “Geographic classification for Health-GCH. Project to develop a rural/urban classification for NZ health policy and research.” Presentation to Health Workforce Advisory Board, October, via Zoom.

<sup>6</sup> Draft report Kaiāwhina Workforce Data Collection, Health Workforce Directorate, Ministry of Health, 26 August 2020

<sup>7</sup> Health and Disability System Review, 2020. *Health and Disability System Review- Final report- Purango Whakamutunga*. Wellington: HDSR, p184.

Initial scoping by the Ministry’s Health Workforce Directorate establishes an incontrovertible case but the breadth and complexity of building a coherent national workforce dataset should not be under-estimated given the potential scope of the unregulated workforce. Longer term commitment to prioritising this data-gathering will provide New Zealand with critical whole-of-system data that it currently lacks.

**It is recommended that developing a coherent national workforce data set encompassing the non-regulated workforce including kaiāwhina be prioritised for investment in health workforce data gathering and that proof of concept work be undertaken in 2021.**

### **3.3.2. Value of the health workforce**

A neglected topic in health workforce planning is the value of the health workforce, both socially and economically. The Health Workforce Advisory Board commissioned in 2019-2020 independent research in the Health Workforce Directorate on the costs of the New Zealand health and disability workforce and the value of employment in the health sector to the economy and society.

The research began before the COVID-19 alerts and national and regional lockdowns that followed, but the global pandemic reinforced the desirability of research that complements public approval of health workers with contextual and factual details of their contribution.

Evidence is provided in the research of the economic and social returns of investing in the health and disability workforce to provide a basis for health and financial decision-makers to work together around shared goals and public finance objectives. The research provides a platform for a stronger dialogue with the Minister of Finance and Treasury about the contribution made by health systems to reducing social and economic exclusion and to economic growth. It suggests that health and inclusive economic growth are complementary and not opposing goals. The paper aims to reposition public debate towards health sector employment as investment with an economic footprint and a labour market dynamic of its own, in contrast to the deficit orientation of health employment as consumption cost only.

The research identifies that the health sector is the second largest employer in New Zealand at 213,000 people, representing nine per cent of those employed in New Zealand. The workforce is predominantly female at 83 per cent compared to 48 per cent across all industries and it is apparent that women drive wealth creation through their employment in the health economy and the consequent familial and social benefits help build inclusion and cohesion.

In five regions of New Zealand health care and social assistance employment is the highest ranked industry by number of employees, and in seven other regions it is second or third. In the most populated northern region the four DHBs collectively are the largest employer with over 26,000 workers in 223 different roles.<sup>8</sup> The value of the health workforce research indicated that health institutions can be viewed as “anchor institutions” a term used to describe the fact that in tough economic times they are economically and socially connected to the communities in which they are based. They, therefore, act as economic stabilisers. This has particular salience as New Zealand faces the critical challenge of unemployment and under-employment as a consequence of COVID-19. The research cites evidence showing that health sector employment tends to be less sensitive to

---

<sup>8</sup> Northern Region Workforce Deep Dive. Workforce Strategy Group Presentation. 28 November 2019.

cyclical fluctuations than employment in other sectors. It also makes a strong case for the health sector as a creator of jobs in deprived areas and regions in an economic downturn.

The research report is attached.

## **4. Enabling greater participation of Māori in the health workforce and partnering with Māori to better understand the needs and aspirations of the Māori workforce**

### **4.1. Māori health workforce crisis**

Māori health inequities are powerfully indexed to inadequate representation across the primary, secondary and tertiary health workforce. Figures show Māori are between six to nine per cent of nurses and midwives, only two to five per cent of New Zealand's dentists, doctors, physiotherapists, pharmacists and oral health practitioners and less than two per cent of radiation therapists and laboratory scientists. For example, the current disturbingly low recruitment and retention of Māori midwives with a turnover of 20 per cent is impacting on whānau at a time when Māori babies are 28 per cent of babies born in New Zealand. The shortage is acute in some rural areas.

Prioritising solutions to these gaps is critical. There has been a relentless tide of information about Māori health inequities. But despite significant Māori academic evidence, statistical data, policy advice and iwi and whānau advocacy addressing this criticality over many years, the step change required at a whole of system and inter-sectoral levels to attract, educate and train, recruit and retain Māori health workers to achieve equity and reflect te Tiriti has failed to occur.

The current COVID-19 environment brings into sharp focus public aspirations to close the gaps for Māori in social and economic outcomes. These aspirations position health centrally, as a potent indicator and determinant of wider equity. The down-stream impacts of Māori gross under-representation in the health workforce has driven consequent pervasive, wide-spread limitations on the health sector's capacity and capability to respond effectively and responsively to the needs of Māori, at all levels. Inadequate health workforce participation contributes both directly, and indirectly, to the enduring inequity in health outcomes for Māori when compared with non-Māori. Māori workforce development requires urgent action as a matter of priority to address the Treaty breaches identified in the Waitangi Tribunal's Hauora report, Wai 2575, and the recommendations of the Health and Disability System Review report.

The acceleration of Māori representation and participation in the health sector workforce requires system-wide action including implementation of strategies and accountabilities based on matauranga Māori and on kaupapa Māori approaches for both regulated and non-regulated workforces. This requires review and action relating to the pipelines and pathways into and through the relevant educational entities, and continuing responsiveness from the training and educational sectors. A critical feature will be ensuring the dismantling of existing barriers to accessing vocational training and the tertiary education sector by Māori school leavers, by Māori with Recognised Prior Learning, and by Māori kaiāwhina and others who wish to transition within the health workforce.

Nursing Council figures show Māori nurses are at 7.5 per cent of the 61,165 nursing population, whereas Māori make up 16.5 per cent of the overall population. The nursing pipeline is a critical issue, according to the Māori co-leader of the National Nursing Leadership Group, Lorraine Hetaraka. She says that data from the health consultancy, TAS, which manages advanced choice of the

employment process shows limited growth in the number of Māori nurses coming through nurse entry into practice and a slight increase only in nursing entry to specialist practice over the past four years. There has been little growth in Māori taking up clinical leadership roles such as charge nurses, nurse educators and directors of nursing or in governance.<sup>9</sup>

The impacts of Māori under-representation are wide-spread including: a lack of patient concordance; a lack of role modelling of pathways into health professions for Māori youth; fewer Māori to take on representative roles and provide expertise; fewer Māori to inform health sector and service problem solving and decision-making; marginalisation and invisibility in leadership positions; and professionally, colleagues and healthcare teams missing out on understanding of cultural competency and te Tiriti. This leads to isolation of Māori health professionals and high expectations on a small number of people.<sup>10</sup>

The Health and Disability System Review's final report recommends that the proposed Māori Health Authority should lead the development and implementation of a Māori workforce strategy.<sup>11</sup> Two Māori Board members, Professor Jo Baxter and Lorraine Hetaraka, have worked with the Ministry's Māori Directorate on *Whakamanawanui: Māori Health Workforce Action Plan 2020-2025* which positions the current state of the Māori workforce against a desired state using specific criteria for initiatives. Some elements requiring change include:

- Ensuring the supply for Māori health workers meets or exceeds demand and at least reflects population demographic and Māori health need
- More Māori see the health workforce as a desirable, accessible and achievable career option
- Māori are, at least proportionately represented in governance, leadership and specialist health roles throughout the health sector
- Succession planning has a clear commitment to Māori engaging in key roles in the system (e.g Māori GMs in DHBs)
- Data, research and trend analysis is responsive to the needs of Māori Health Workforce Development and is available in the Ministry to better understand the Māori health workforce and aid planning
- Māori who work in the health sector are valued and supported to engage fully in their workplaces, including valuing of Māori workforce cultural expertise and understanding of te ao Māori
- Specific investment is made to ensure Māori focussed initiatives are able to reflect demand and equity and this includes in relation to the health workforce component of these initiatives
- Increase in the pipeline of Māori into and through health workforce roles (regulated and nonregulated) focusing on all areas including: akonga/students; working age adults; and transitions between different parts of the health system
- Identification and targeting of vulnerable workforces critical for Māori health and growth areas for support
- Greater strategic engagement of Māori in health workforce policy, strategy at all levels.

---

<sup>9</sup> Longmore, M (October ,2020). "Growing the workforce takes time, resources". *Kai Tiaka Nursing New Zealand*. Vol 26. No 9. pp18-19.

<sup>10</sup> Baxter, J. and the Māori Health Workforce Development Unit Team, "Creating pathways to equity: a 10 year journey in Māori Health Workforce Development." Centre for Hauora Māori, Division of Health Sciences, University of Otago, October 2019. Presented to the Health Forum, Wellington.

<sup>11</sup> Health and Disability System Review, 2020. *Health and Disability System Review- Final report- Purango Whakamutunga*. Wellington: HDSR, p 24.

Poor Māori health workforce representation reflects a failure of the health system and does not reflect te Tiriti, but there are examples of good practice and new initiatives that require continuing investment and support. Continuing investment complements the acknowledged need for a joined-up approach to health workforce attraction, education and training, recruitment and retention accompanied by investment in Māori health knowledge. Several of the positive initiatives include:

- Tumu Whakarae, the group of DHB Māori GMs securing commitment from DHB CEOs for targeted Māori recruitment across hospital workforces
- The Voluntary Bonding Scheme placing health professionals in rural or disadvantaged areas, which had a 16.6% Māori participation in 2019
- University of Auckland's MAPAS programme which has delivered a range of highly effective programmes to grow the numbers of Māori across programmes in health including medicine, nursing and pharmacy
- University of Otago's Mirror on Society pathways for Māori into and through its health professional programmes (dentistry, medicine, oral health, pharmacy, physiotherapy, medical laboratory science, radiation therapy, dental technology, graduate nursing) in order to address historic patterns of under-representation in the health workforce
- Māori nurse education including Manukau Institute of Technology's Bachelor of Nursing, Te Tohu Paetahi Tikanga Rangatira ā Tapuhi; Whitireia Institute in Porirua has offered a Bachelor of Nursing since 2009 and Te Whare Wānanga o Awanuiārangi in Whakatane offers Te Ōhanga Mataora, Bachelor of Health Sciences Māori Nursing
- Ngā Manukura o Āpōpō which is the only national Māori Nursing and Midwifery Leadership Programme in Aotearoa
- Kia Ora Hauora Programme – a nation-wide programme aiming to support Māori secondary school aged students, and Māori adults to raise awareness of health pathways, and to grow the number of Māori on pathways in health
- Rangatahi Programme, which is a secondary school feeder programme
- Seat at the Table, a new Ministry-DHB initiative for young Māori board observers to learn about health sector governance, which was introduced into six DHBs in 2020.

The Ministry's Health Workforce Directorate is working closely with the Māori Health Directorate on *Whakamanawanui*, the Māori Health Workforce Action Plan, which has purposeful strategies and actions identified for implementation. However, Māori workforce under-representation is a crisis for the sector and unless it is acknowledged as such, incremental initiatives, no matter how worthwhile, will not solve the pervasive inequities. For transformational change to occur appropriate resourcing must be allocated with iwi direction for Māori health workforce development and accountabilities for change in primary, secondary and tertiary care. One lever would be a purposeful and transparent approach to all Ministry-funded contracts detailing a proportion of Māori workforce involvement. These mechanisms will help but not fully address inequities in the Māori health workforce.

**It is recommended that the Minister of Health prioritises acceleration of the Māori Health Workforce Action Plan and the development of an accountabilities framework for implementation that is co-designed with iwi.**

## **5. Enabling greater participation of Pacific and other under-represented populations in the health workforce**

### **5.1. Pacific**

Pacific representation in the regulated health workforce is low. While 8 per cent of the population is Pacific, Pacific peoples make up only 3.8 per cent of the nursing workforce, 1.8 per cent of medical doctors and less than 1 per cent across all other regulated health workforce areas. This under-representation is acute given that Pacific peoples are over-represented in poor health outcomes and the gaps are not closing.

Potential avoidable deaths are twice as high among Pacific peoples, diabetes prevalence is 20 per cent compared with 10 per cent for Māori, 8 per cent for Asian and 6 per cent for New Zealand European. Rheumatic heart disease is 50 times higher in Pacific children compared to New Zealand European, the highest of all ethnic groups.

The persistent inequities in health for Pacific peoples demand deliberate and purposeful changes in health delivery. COVID-19 illustrated that when health responses are culturally empowered and embedded, communities are more likely to be responsive.

A multi-system approach involving training institutions, the Ministry of Health, regulatory authorities, DHBs, and community and primary care organisations is required to build a Pacific health workforce. The Health and Disability System Review indicated that growing the Pacific health workforce is essential.

Led by Associate Professor Fa’afetai Sopoaga, the Board has advised the Directorate that a Pacific Health Workforce Strategy should be developed in the coming year with the appointment in the Directorate of an equity advisor. The development of a Pacific Health Workforce aligns with the Board’s terms of Reference that refer to “enabling greater participation of Pacific”, and with the work of the Pacific Expert Advisory Group led by former Associate Minister of Health Hon. Jenny Salesa.

In the first year it is anticipated that the scoping of a Pacific Health Workforce Strategy will examine data collection and a stocktake of current Pacific workforce numbers with the help of professional stakeholder organisations.

The educational pipeline is critical to a Pacific Health Workforce Strategy. The Health Science Academy Programme led for the past four years by Counties Manukau DHB in South and West Auckland is aimed at encouraging secondary school pupils into health sector careers. It was successfully piloted in seven Auckland secondary schools and was extended in 2020 to include six more schools. Scaling up the Health Science Academy Programme as a national approach is strongly endorsed by the Board as cost effective, low risk approach with proven outcomes for individual careers and community cohesion for Pacific communities.

**It is recommended that the Ministry of Health with guidance from the Pacific Expert Advisory Group and the Health Workforce Advisory Board increase the Health Science Academy Programme by scoping additional participation from schools in Hamilton, Wellington, Christchurch and Dunedin/Otago from 2021.**

## 5.2. Disabled people

The Board's Terms of Reference includes advice on improving the health sector workforce participation of "under-represented populations". People with disabilities remain marginalised and disadvantaged in the health workforce despite reference to disability in the legislation and in many strategic documents that encompass "health and disability" but often place less measurable emphasis on disability. The Interim Report of the Health and Disability System Review suggested that the DHBs needed to lead by example in the employment of disabled people as the largest employer in many regions.<sup>12</sup> Boosting the employment of disabled people overall may be the biggest single contributor to improving their wellbeing, the report said.

In the Letter of Expectations for DHBs and statutory entities for 2020/21, the former Minister of Health told these organisations that they "should look for opportunities to increase employment of disabled people to improve the competency and awareness of your workforce" ... and told DHBs that they must make progress towards implementing the United Nations Convention on the Rights of Persons with Disabilities.<sup>13</sup>

Additionally documentation referring to the development of Annual Plans by DHBs refers to the need for Disability Action Plans that focus on data, access and *workforce*.

In consultation with the Disability Directorate of the Ministry of Health, the Health Workforce Advisory Board believes it is appropriate and timely for the Minister of Health to increase expectations of DHBs through the annual planning cycle and the Letter of Expectations process.

Increased employment of disabled people is a powerful equity indicator and could accelerate wider knowledge and understanding of health gains for disabled people. However, targeted progress may be slow to occur when the opportunities of employing disabled people are aspirational only.

**It is recommended that the Minister of Health uses the Letter of Expectations to increase the recruitment of disabled people in DHB health workforces (both clinical and non-clinical staff) and that targeted progress be monitored and published annually by the Ministry of Health.**

## 5.3. Non-regulated workforce representation

A key function of the Board is to provide advice to the Ministry on any sector engagement or advisory groups that may be required to support the work of the Board. The Board had discussed with the previous Minister of Health, Hon. Dr David Clark, the desirability of adding Kaiāwhina representation to HWAB but the process was delayed by the 2020 election process.

Kaiāwhina representation on the Board would provide a critical perspective for many thousands of essential health workers working in aged care, community, DHBs, primary care and social settings.

The Health and Disability System Review noted that taking a strategic approach to growing the kaiāwhina workforce over the next five years will be a key to achieving a step change in the delivery of services.

---

<sup>12</sup> Interim Report Health and Disability System Review, p.14.

<sup>13</sup> Clark, David, Hon. "Letter of Expectations for District Health Boards and subsidiary entities for 2020/21." Appendix One: Ministerial Planning Priority Areas, p.7.

HWAB representation would complement the Kaiāwhina Workforce Action Plan 2020-2025 which is a partnership between Careerforce, the relevant industry training organisation, and the Ministry. It would also provide an essential voice during the scoping of work by the Health Workforce Directorate to undertake the first ever stocktake of the unregulated health workforce in New Zealand.

**It is recommended that Kaiāwhina representation be added to the Health Workforce Advisory Board as soon as possible to acknowledge both the value and voice of a large number of non-regulated health care workers.**

## 6. Education, training and development of the health workforce

### 6.1. Workforce flexibility

The imperative for health workforce flexibility was exacerbated by the global pandemic which provided an impetus for urgent change to deliver a modern, fit-for-purpose health system. New Zealand is not immune to worldwide trends of the growing clinical workforce shortages. The long-term impact of COVID-19 on the supply and demand for international medical graduates and the emigration of New Zealand trained health professionals seeking overseas experience, remains unpredictable. In the short term a more stable health workforce is a consequence of travel restrictions. But the COVID-19 disruption provides the right opportunity to ask again whether the current health workforce and how it is trained and deployed prepares us for future change, including the normalisation of dealing with transmittable viruses.

Perennial workforce limitations relate to rigid scopes of practice, protection of professional boundaries, difficulties attached to extending operating hours for some services and deploying health professionals differently, encouraging generalisation as well as specialisation in training and education, and using new and integrated models of care.

The Health and Disability System Review's final report acknowledges that the current system is an inherited one and categorically states that "the types of regulation, professional silos, provider-based system, treatment, and highly medical model that has evolved will not meet future needs."<sup>14</sup>

Two of its recommendations are relevant here: the need to improve the training environment and encouragement of the regulatory environment to become more flexible. An example in the sector which has become emblematic of the current inflexibilities concerns anaesthetic technicians in New Zealand who have a longer training period of three years (compared with two in the United Kingdom) with some plans by tertiary institutions to increase this to four years at a degree level. They also have a more limited scope of practice here than other comparable jurisdictions. MRI technicians are another group with longer training required in New Zealand at a time when there is a ballooning wait list for medical imaging.

Currently 17 Responsible Authorities are responsible for 24 regulated professions. They derive legitimacy from the Health Practitioners Competence Assurance Act 2003 and are currently responsible, amongst other functions, for accrediting training programmes and providers and prescribing scopes of practice. They ensure health practitioners are competent and safe to practice.

---

<sup>14</sup> P.183.

The Responsible Authorities have complete autonomy in setting accreditation standards, but without the consequent responsibility for policy settings relating to accreditation standards, which are required for a responsive and rapidly changing health sector. For example, a College needs to have a selection process for entry to training but the success or otherwise of such a process, including its effectiveness in addressing issues such as the need for a rural workforce, is not relevant to an accreditation standard. Two other concerns include the curricula which are generally not rapidly responsive to changing health needs and dynamics, such as emerging diseases secondary to climate change and/or immigration; and technological advances driving subspecialisation especially in interventional specialities which further threatens generalist training. The sentinel question remains whether the “medical guilds can become effective socially beyond intrinsic guild-need and play a role in preventing and mitigating, and in responding to health system failures.”<sup>15</sup> Bi-national medical colleges face increasing challenges around the divergence of New Zealand and Australian health systems so it is timely to reflect to reconsider roles. Such a reconsideration would require cooperation and open-mindedness from Responsible Authorities characterised by autonomy and adherence to individual professional boundaries.

The importance of striving for a more representative and diverse health workforce, and the many benefits to the health of our diverse populations are well recognised. But barriers exist when the education sector is a gatekeeper and not an enabler of health workforce composition across key equity domains. The education sector holds the key to entry into health professional training. It determines access to, and effectiveness of, education pathways for those aspiring to be health professionals, including those who are from under-represented groups e.g Māori, Pacific peoples, students from low socio-economic backgrounds and people living with disability. Although initiatives led out of the health sector can raise awareness about taking up roles in health, it is the education sector that ultimately determines who gains entry to health training.

To reduce institutional barriers and align education and training with future and current workforce needs, the health and education sectors need to purposively change, engage in structured collaboration, and make transparent progress towards the training of priority groups (e.g Māori, Pacific peoples, people with disabilities). Equity gains in health workforce representation must be accelerated for access to services by vulnerable and disadvantaged populations and for their health outcomes to improve. More broadly, there are significant benefits for the health workforce in having a closer and more focussed relationship between health and education sectors over the health workforce pipelines, as well as ensuring synergy between programmes offered and the requirements of the health sector.

The Health and Disability System Review’s recommendation was that “*the Ministry should work with the Tertiary Education Commission (TEC), Health NZ, the new New Zealand Institute of Skills and Technology (NZIST) and other regulatory authorities and training establishments to ensure all relevant training is consistent with the goals of the NZ Health Plan and accompanying strategies.*” For this to be realised, a more purposeful and directive approach to such collaboration, with possible legislative change to provide for clarity of mandate, will be required.

---

<sup>15</sup> Gorman,D. (2017). “Medical colleges: whose purpose, if any, do they serve?” *Internal Medicine Journal*. Vol 47, Issue 3, p.1. <https://onlinelibrary.wiley.com/doi/full/10.1111/imj.13355> Accessed 25/02/2020.

**It is recommended that the Ministry of Health leads a consultation process with responsible authorities and training and education providers about the collaborative mechanisms and processes and possible regulatory changes required to realise the ideal of relevant training being consistent with New Zealand’s current and future health workforce needs.**

## **7. Recruitment, retention and distribution of the health workforce**

The global pandemic propelled dramatic change for the health sector workforce and is likely to displace traditional thinking relating to recruitment, retention and distribution of the workforce. There will be enduring shortages of some general and specialised workforces due to travel restrictions and limited international mobility and there could also be pockets of over-supply. Perennial pipeline problems are likely to persist. There are numerous examples of mal-distribution of specialist workforces. At a time of renewed urgency to address equity of Māori representation at all levels of the health workforce there are not enough Māori teachers in secondary schools teaching science subjects and consequently not enough young people with the requisite entry subject requirements.

### **7.1. Rural workforce**

New Zealand, too, has yet to fill its enduring shortage of rural GPs and faces shortages of midwives, dentists, physiotherapists, and pharmacists as well as too few social workers working in the health and wellbeing area. Some specific areas such as the far north and the West Coast face continuing, chronic recruitment and retention problems.

The Ministry's Health Workforce Directorate has undertaken a programme of work on rural health workforce over the past 12-18 months, including a focus on the need for greater investment in rural inter-professional learning. Significant interest from rural communities in expanding rural inter-professional learning programmes followed the announcement of the scoping of rural training hubs in April 2019 by the then Minister of Health, Hon. Dr David Clark. Evidence shows that having a rural background and experience in rural areas during undergraduate and/or postgraduate training increases the likelihood of health professionals practising and remaining in rural areas during their career.

The Ministry has worked with the rural sector during 2020 to identify a preferred option for a new rural inter-professional initiative. This preferred option would see inter-professional cohorts of students learning rurally for at least one year, which is a significant change to existing inter-professional immersion programmes of five weeks.

While the inter-professional initiative has sector backing, the rural health workforce remains of continuing concern as New Zealand faces a new normal in the post-pandemic dynamics of the health sector workforce. Experience shows that a key Tier One sustainability factor for the rural health workforce is the ability to “grow our own” with health employment being a whole of community focus. Rural recruitment and retention depend on communities attracting and recruiting families not just single health professionals. The provision of quality housing, schooling, lifestyle options, plus the prospects of meaningful and satisfying professional work that is adequately paid, are determinants. “Growing our own” also involves greater acknowledgment and use of nurse practitioners and physician assistants as a substantial value pool.

An enduring key challenge facing the rural health workforce relates to the lack of a coherent voice or a peak body that has oversight, input and coordination of rural strategic planning issues as they affect the workforce at a systems level. A strategic rural health plan will help fill data gaps on deprivation, workforce shortages, models of care and inequity of outcomes. The creation of a rural health director role is worthy of consideration to ensure that there is oversight of all rural issues, inclusive of workforce, across the Ministry.

A temptation of COVID-19 is to see the adoption of telehealth and virtual care as a panacea for rural health workforce gaps in service delivery, rather as an enabler in remote care settings to ensure equity of health access and outcomes. While there is room for greater adoption of telehealth across the system, the rural health care inequities will not be solved by policy assumptions that virtual care options can deliver “care anywhere”. Māori health inequities in rural areas are best addressed by culturally responsive approaches that require trust and face-to-face interactions.

## 7.2. COVID-19

COVID-19 will both positively and negatively disrupt recruitment and retention for some time. For example, RMOs are in an increasingly competitive environment in 2020. The Northern region is finding a shortage of DHB employed Registered Nurses for quarantine and managed isolation work at the same time as DHBs work to improve acute and planned care backlogs requiring the same pool of Registered Nurses. Added to the new COVID-19 environment, there are existing inter-generational pressures with an ageing health workforce and a change in the career aspirations and work expectation of younger graduates wanting portfolio careers, rather than a life-long commitment to a specific organisation. If COVID-19 is an impetus for change then it provides a real opportunity to look again at the Recognition of Prior Learning, which has not been an accepted retention practice, resulting in many skilled staff leaving the sector rather than retraining. For example, a nurse who wishes to become a physiotherapist has to start again to retrain without cross crediting previous qualifications or recognition of on the job development. This represents a loss of human capital at a time when transferability of skill-base, knowledge and experience are at a premium because of the pandemic interruptions to international health worker mobility.

### 7.2.1. COVID-19 change examples

However, at least two COVID-19 related health workforce recruitment examples demonstrate that incorporating matauranga Māori, and new ways of thinking about the skills required, were purposefully employed in the health sector in response to the pandemic. While these examples are specific to the exceptional context of COVID-19, they are illustrative of more agile recruitment and retention at the community level.

The mobilisation of an informal Māori health and wellbeing workforce demonstrated matauranga Māori adaptability in lockdown levels. Diverse Māori providers and organisations across health, social agencies, iwi and NGOs identified needs, particularly of the most vulnerable such as homeless, rurally isolated or those with high health needs, used mobile clinics, home visits and marae settings to ensure a continuity of food, medications, and follow-up care. For example COVID-19 allowed for greater penetration of flu immunisation for older Māori, reducing winter demand on hospital services. Māori providers adapted to the home or the marae as the places where care could be provided and delivered door-to-door prescriptions for diabetes and other medications for patients too afraid to venture out.

Additional and specifically targeted funding by the Government allowed for this workforce responsiveness. Continuity of resourcing is required to ensure diverse Māori providers and

organisations retain and develop their capacity for flexibility, adaptability and responsiveness of their workforce to address health inequities. Similar flexibility and self-initiative by Pacific communities during the second Auckland Alert Level 3 period demonstrated that culturally embedded responses were agile, appropriate and wrapped around communities to respond to the transmission of COVID-19 in a way that the traditional medical/hospital services/community outreach could not, and would have failed.

The second example relates to the development of a training and development module for COVID-19 virus swabbing to upskill additional workers to reduce reliance on Registered Nurses. Careerforce, the Ministry of Health and the health sector including DHBs helped develop an online module to support the training of health care workers including kaiāwhina. The e-learning which has been developed comprises one element in a three-part training programme, along with practical training and practical assessment. The swabbing module is an agile response to health workforce issues with the likelihood of COVID-19 surges and the desirability of continuing surveillance testing in workplaces by employers.

COVID-19 has resulted in considerable workplace dislocations with high redundancies and increased unemployment in some sectors. Several of those sectors such as hospitality and tourism, and retail sales, have a strong component of face-to-face service, which is an essential skill required for many front-line health sector jobs. The pandemic underlines, again, the need for greater Recognition of Prior Learning to be embedded in career change in the health sector, coupled with increased on-the-job training and micro-credentialling approaches to learning and education. There has not been a more apposite time for a changed and increased entrepreneurial approach to whole of system health sector recruitment.

**The Board recommends to the Minister of Health that ongoing investment in the new rural inter-professional initiative be prioritised to help support the sustainability of the rural workforce and specifically address significant inequities of health outcomes for rural people, particularly rural Māori. The Board also recommends that the creation of a rural health director role be considered in the implementation of the health and disability system reforms.**

## **8. Health workforce wellbeing**

Challenges relating to wellbeing will arise for the health sector workforce as the management of COVID-19 becomes part of an abnormal ‘normal’ and New Zealand learns to live with the global pandemic. The psycho-social impacts of COVID-19 are beginning to emerge for clinical and non-clinical staff alike across containment, management and eradication of the virus. Whether health staff are involved in decision-making at incident management level or coping with surges in community transmission, or working in managed isolation and quarantine facilities, involved in contract tracing and surveillance testing, or rostered in ICUs and wards managing serious cases that are admitted to hospitals, there will be psychological consequences attached to patient care and the expansive empathy required.

The most obvious wellbeing issue relates to the immediate fear and anxiety of essential workers for themselves and their families and whānau of the heightened risks of contracting the COVID-19 virus, what a front line clinician has called “distinct exposure”. A related challenge is how health workers are supported to manage the pressures of constant preparedness, heightened vigilance and burnout. The District Health Board workforce, for example, is in many cases working in parallel streams of COVID-19 and catching up in planned acute and elective care. General practitioners are

concerned that the overseas supply of locums to support their delivery of primary care will be interrupted jeopardising patient care and service delivery. Other health workers, such as allied health staff, are adjusting to disrupted and different ways of delivering primary care for patients who may not be able to be seen in person with the risk of accelerating unmet needs.

Equally health care workers are concerned at the long term impact the pandemic will have on their mental health. Interrupted leave management caused by COVID-19 is common across primary, secondary and tertiary health services. Increased additional sick leave as a consequence of COVID-19 “stay at home if you are unwell” consciousness, is impacting on hospital staff rostering and the recruitment of Registered Nurses for swabbing and testing, in particular. Lower paid health care assistants, predominantly women, often work across various facilities such as aged residential care and other health settings, with two or even three different employment relationships, out of financial need. While it is desirable to have dedicated workforces to minimise COVID-19 transmission in the community, this may have negative consequences for the take home pay for predominantly women health workers and their families.

The need for surge workforces and the pressure of acute and elected backlogs is resulting in cancelled leave, increased overtime and staff being asked to volunteer for extra shifts. Familial financial stresses have seen an increase in professional staff requesting leave buy-out. Frontline staff have faced an increased workload without a proportionate increase in staffing levels as DHBs face financial sustainability issues. The resultant health worker burnout could impact long term on staff retention, despite the current, apparent hospital workforce stability because of COVID-19 travel restrictions.

Many health organisations, DHBs, primary care institutions, GP and allied health organisations have realised the need for increased wellbeing communication to staff, have introduced resilience and stress training and have strictly enforced staying at home for unwell staff. In addition Employer Assistance Programmes are available in DHBs and other workplaces. However, the medium and long term effects of working with COVID-19 as a health worker have yet to be manifest and may require a different imagination of how staff can be supported working within a pressured sector.

**COVID-19 emphasises the need for innovative and novel occupational health and safety approaches including psycho-social support for the health workforce located both in hospitals and across primary and community care.**

## **9. Supporting quality improvement, innovation and changed ways of working**

### **9.1. Telehealth**

The dramatic switch to telehealth (telephone and video conferencing) by DHBs during national and regional COVID-19 lockdowns demonstrated the critical potential of lasting and sustainable telehealth services post lockdown. An exponential increase in telehealth by the 20 DHBs saw 32,000 consultations to patients in one week alone in April 2020.<sup>16</sup> While these figures have dropped markedly since the peak of the COVID-19 response (down to 18,300, June-August 2020), DHBs are assessing telehealth capability and services and the support and enablers to ensure a sustainable and quality service.

---

<sup>16</sup> Health Informatics New Zealand (Tuesday, 29 September, 2020). “Exclusive: Massive rise in telehealth at DHBs revealed.” eHealthNews.nz: News article. <https://www.hinz.org.nz/news/528449/Exclusive-massive-rise-in-telehealth-at-DHBs:HTM>.

One DHB has estimated the collective travel, carbon and financial savings of the 26,504 patients who received telehealth between 23 March-July 3, 2020, at \$3,962,082 in costs avoided (mean \$149.49 travel and loss of earnings).<sup>17</sup> Patients' experience data collected at the DHB through 44 interviews of patients receiving telehealth in March 2020 indicated a 95 per cent positive response to the service and of the notion of patient choice. Many patients said they would prefer video consultations rather than telephone consultations, which were by far the majority of telehealth consultations received during the pandemic.

The use of telehealth during COVID-19 against clinical and quality guidelines, dispelled concerns that clinicians and doctors would be slow adopters. But it did expose the need for a whole of system telehealth resourcing to ensure the effectiveness of such things as the integration of video software with booking systems, patient choice being built into booking systems, electronic tools such as e-prescribing, e-patient outcomes forms, among other elements.

The Ministry of Health's Digital and Data Directorate has initiated a digital technology national intentions collaboration within DHBs to ensure coordination and efficiencies and economies of scale across the hospital sector. In addition to this collaboration in the adoption and implementation of new digital capabilities, the health workforce implications require attention so that telehealth does not become a missed opportunity. Workforce issues encompass human capital and digital literacy, in addition to the service improvements envisaged in the national intentions collaboration.

Consideration could be given to:

- the cross-sectoral advantages of the regional northern Digital Academy which concentrates on clinical leadership, becoming a nationwide programme
- the inclusion of measurable key performance indicators relating to telehealth in the employment agreements of incoming clinical staff to enhance capacity and capability
- the desirability/feasibility of an international telehealth network drawing on overseas specialists to provide virtual follow-ups in hard to staff specialties such as ophthalmology and dermatology
- the use of telepods and other digital mobile options in both hospital and community locations to provide patient choice and assist with follow-up consultations and health protection
- the need for all digital platforms to have embedded cultural competence and for virtual care to be delivered in a culturally responsive manner.

Without consideration of the workforce implications of telehealth, the telehealth gains of COVID-19 are likely to be *ad hoc* and variable, or worse, could dissipate. Given the possible durability of COVID-19 or other similar pandemics, the sustainability of digital consultations may be critical for patient care and the exercise of clinical responsibilities. The health sector talks often about consumer choice. The test of its commitment now is how it harnesses the evident patient demand for telephone and video follow-up consultations to avoid travel and minimise lost work-time costs, while maintaining the best possible clinical outcomes. Embedding digital literacy at all levels of the health workforce will be critical if digital transformation is to be a key element of the post-pandemic financial sustainability and health services recovery.

---

<sup>17</sup> Telehealth: A Discussion Paper. Waitemata District Health Board Consumer Council Meeting 22 July 2020.

## **10. Conclusion**

The first Health Workforce Advisory Board Annual Report to the Minister of Health was written at a historic time of pandemic responsiveness and of health sector reform involving structural change. Systemic and direct attention to health workforce issues will be critical to the success of the implementation of the Health and Disability System Review and the Board and the Health Workforce Directorate are enthusiastic about collaboration with the Transition Unit. Most of the changes have been signalled in various government reports, academic research studies and policy papers, for a number of years. These have included regular calls for strategic planning and whole of system responses to critical workforces, supply and demand and eliminating health inequities in representation and participation of the Māori health workforce. New Zealand's experience of COVID-19 reveals that many of the required changes should not wait any longer given the potency of climate change, the likelihood of other pandemics and potential surges of preventable diseases that were previously eliminated. The tumult of COVID-19 also provides the brightest of opportunities for innovation.

The Board's first year was dominated by COVID-19 responsiveness and social distancing with members meeting primarily by Zoom and not face-to-face. As a priority the Board will in the 2020-2021 year engage directly both regionally and with a wide variety of representation with the aim of profiling health workforce issues and to advise the Minister of Health of critical elements relating to attracting health workers, their education and training, recruitment and participation, wellbeing and job retention.

Judy McGregor, Chair

Jo Baxter, Member

Ailsa Claire, Member (ex-officio)

Andrew Connolly, Member

Lorraine Hetaraka, Member

Karl Metzler, Member

Sophie Oliff, Member (resigned October 2020)

Fa'afetai Sopoaga, Member

Madeleine Matthews, Board Observer.

## Membership of the Health Workforce Advisory Board

**Judy McGregor** is the Chair of Waitematā District Health Board and has held previous governance roles such as the Equal Employment Opportunity Commissioner for the New Zealand Human Rights Commission. In 2016 she won the Supreme Award for Women on Boards from Governance New Zealand. Professor McGregor is also the Associate Dean Postgraduate in the Faculty of Culture and Society at the Auckland University of Technology (AUT). She is patron of the Auckland Women's Centre.

**Jo Baxter** has a clinical background in public health medicine and experience in medical education. Dr Baxter is the Director of the Māori Health Workforce Development Unit at the University of Otago, which supports initiatives to grow the Māori health workforce through increasing the recruitment, retention and graduation of Māori health professionals

**Ailsa Claire** is the Chief Executive of Auckland District Health Board and the Lead DHB Chief Executive for health workforce. She holds the ex-officio member position on the Board.

**Andrew Connolly** is a general surgeon with Counties Manukau District Health Board and a Board member of the Health Quality and Safety Commission. Mr Connolly was a Ministerial Appointee to the Medical Council of New Zealand from 2009 to 2019, which included a five-year term as the Chair. In this capacity he has led changes and improvements in resident doctor education, recertification for specialist doctors and the profession's approach to health inequity. Mr Connolly is currently a Deputy Commissioner for Waikato District Health Board.

**Lorraine Hetaraka** (Ngāti Kahu, Tapuika, Ngāti Pikiao, Ngāti Ranginui, Ngāiterangi) is the Nurse Leader for the National Hauora Coalition, with experience as nurse lead in three other primary health organisations, as well as the Auckland District Health Board. Ms Hetaraka is currently co-Chair of the College of Nurses Aotearoa, and Chief Executive of Te Arawa Whānau Ora.

**Karl Metzler** is the Chief Executive of Gore Health Limited, a rural community-owned charitable trust hospital and healthcare facility that incorporates emergency, inpatients, allied health, x-ray, laboratory, oral health, general practice and primary maternity services. He is also the Chair of the New Zealand Institute of Rural Health and sits on Southern District Health Board's executive leadership team part-time to assist in various change management initiatives. Mr Metzler has a background in mental health, working as a clinical psychologist, service manager and national workforce manager with Te Pou to develop a workforce strategy for the mental health sector.

**Sophie Oliff** trained as a pharmacist and won the Future Pharmacist of the Year Award in 2016. She is the Chair of Ignite Trust, an organisation that builds partnerships between talented students and socially conscious organisations to help maximise their impact, and a member of the World Economic Forum Global Shapers Community. (\*She recently stepped down from the Health Workforce Advisory Board).

**Faumuina Fa'afetai Sopoaga** is the Associate Dean (Pacific) and head of Va'a o Tautai in Health Sciences at the University of Otago. In 2018, she received the Prime Minister's supreme award for national tertiary teaching excellence. Of Samoan descent, she has been acknowledged for Outstanding Leadership to Pacific Communities. She is a Fellow of the New Zealand College of Public Health Medicine and Royal New Zealand College of General Practitioners.

**Madeleine Matthews** is an Observer under the Health Workforce Advisory Board's Seat at the Table initiative. She is a registered nurse with the Capital and Coast District Health Board.