1 Health workforce planning and development

1.1 History of health workforce planning in New Zealand

New Zealand has had limited experience with workforce planning. The first effort at structured health workforce planning occurred in 1976 when a national medical workforce planning workshop was held at Wairekei under the leadership of the Medical Council of New Zealand. The aim was to review the available data on the medical workforce, and advise on organisational arrangements, information systems and research and development requirements needed to improve the planning of the medical workforce. This workshop was followed by similar ones in other disciplines – nursing, dentistry, and physiotherapy, and general health administration.

By 1980 it was clear that a national effort was needed to integrate workforce planning across the health sector occupations. The first national workshop was held in 1982. A set of position papers was commissioned and circulated in advance of the workshop, covering social policy and social planning, health sector planning, educational implications of health workforce planning and health/education interaction.

   Progressively ... a national framework was created to gather and share information, to promote dialogue between health and education agencies and the health professions, and to encourage integrated workforce development. Central to this was a national health workforce development unit within the Department of Health whose task was to energise and co-ordinate these activities ...

   Following the change of government in 1984 political and administrative attention turned away from workforce development towards issues of more immediate impact on financing and managing of health services ...

   The information systems were run down; the planning and networks were dismantled; and the workforce planning section of the department disbanded. In justification, it was claimed that the prime responsibility for workforce development would in future rest with health sector employers and would be exercised by way of the market (Martin and Salmond 2001).

The 1991 reforms rejected the developmental approaches as ‘being an aspect of provider capture and an unnecessary interference by the state in the marketplace. The workforce planning structures and processes which had been put in place by the Department of Health were dismantled’ (Salmond 1997). The collection of health workforce statistics continued, but reporting was minimised. As part of the reforms the funding for post-entry clinical training of the health workforce was unbundled from hospital budgets, and the Clinical Training Agency (CTA) was established in 1995 to purchase post-entry clinical training on behalf of the Regional Health Authorities.

Funding also moved from Vote: Health to Vote: Education. By the mid-1990s it was clear that the complex workforce issues were not being adequately addressed by the market. The problem
was that the product and labour markets continued to function, but prices of health services were effectively capped without any prioritisation process for which services would be provided. Product prices had to be met, but Hospital and Health Services tried to hold down labour prices, leading to conflict and shortages.

The Government rekindled its interest in workforce development with the establishment of the Committee Advising on Professional Education (CAPE) in 1996. The primary function of this committee was to advise the Minister of Health on long-term national policy direction for the education of the health and disability workforce. CAPE held workshops and produced recommendations on educating the health and disability workforce (Committee Advising on Education 1997), and on occupational regulation in the health sector (Committee Advising on Education 1998). That year:

CAPE went on to recommend the establishment of a Crown entity to focus and co-ordinate workforce development and its implementation, sector-wide. The Government rejected this advice in favour of some minor strengthening of workforce activities within the Ministry; and disbanded CAPE (Martin and Salmond 2001).

Also that year the Ministry of Health published an Occasional Paper (Ministry of Health 1998a) signalling that employers in the health and disability sector were better placed than central government agencies to lead the developing of the workforce. Centralised forms of health workforce planning were viewed as not refined enough to take account of the complex influences that affect any labour market. It also indicated the need for collaboration among employers, with input from education and health care workers.

There is currently a renewed focus on workforce planning, both within health and in the wider public sector. The State Services Commission is undertaking a labour market project to look at the role of medium-term forecasting in human resource management for the state sector and what circumstances, if any, are most suitable for the application of forecasting and workforce planning techniques. This is driven by the concern that there may be:

... dramatic changes due to technology, and e-government in particular, which are difficult to predict. These may place considerable pressure on State sector labour markets to adapt to changing demands. It is unclear if the effects of a fixed baseline-funding regime will hinder the capability to respond to challenges of the future (State Services Commission 2000).

With a rise in consumerism and an emphasis on business-like practices, workforce planners are increasingly required to take more account of consumer perspectives, quality issues and the cost of producing services. These considerations may lead to the existing division of labour, role demarcation and regulatory structures being challenged.

1.2 Components of health workforce development

The three major components of workforce development are:

- planning for the quantity and configuration of the workforce
- educating and training to ensure the quality of the workforce
- managing to ensure the performance and retention of an appropriately trained workforce (based on de Geyndt 2000).
1.2.1 Planning the workforce

Planning for the quantity and configuration of health practitioners with any level of precision is becoming increasingly complex due to the globalisation of the health professional workforce. Internationally recognised qualifications, increasing demands generated by technology and the ageing population, and local policy (such as the level of student contribution towards education) can lead to rapid shifts in the available workforce.

The following health workforce planning methods are either in use internationally or have been used in the past. They are:

- workforce to population ratios
- student admissions
- needs-based planning
- demand-based planning
- benchmarking
- models of care approach.

Workforce to population ratios

This method compares workforce numbers with population figures, and until recently was recommended by World Health Organization (WHO). It is easy to apply but depends on norms, which may be arbitrarily set without consideration of epidemiological data or resource constraints, and may lead to an expensive and inequitable distribution of health workers.

Student admissions

This method projects future supply on the basis of student numbers. The major assumption here is that current policies are the correct ones and will remain correct for the next 30 years. For example, it is assumed that the current skill mix among the categories of health professionals will remain unchallenged and unaffected by changes in the external technological, demographic and epidemiological environment.

Needs-based planning

In this method, panels of experts estimate the per capita numbers of physicians and/or other practitioners needed to treat the diseases managed by a given speciality. Using this method requires the ability to forecast the factors that will affect the need for a particular specialist, such as the pace of technological change, the impact of an ageing population and its accompanying increase in chronic and degenerative diseases, and the increasing burden of disease due to violence and accidents.

Demand-based planning

This method assumes current utilisation is a proxy for patient demand and an indicator of practitioner requirements. Utilisation is calculated for hospitals (via discharges, average length of stay, estimated bed days per capita) and for ambulatory care (visits to physicians, dentists, nurses, midwives). This workforce planning method requires projecting current utilisation into the future, taking into account increased utilisation as a result of an increased supply of medical resources, and estimating the impact on demand and service delivery capability of changes in epidemiology and the burden of disease, and demographic changes.
Benchmarking

This compares workforce resources with a benchmark or model region, or with a benchmark health plan, or with other countries with different organisational arrangements. This is generally not done very well in New Zealand. The National Health Service in the United Kingdom has developed a set of six performance indicators related to workforce capacity and capability. They relate to junior doctors’ hours, the vacancy rate for qualified allied health professionals, the vacancy rates for qualified nursing, midwifery and health visiting staff, the vacancy rate for consultants, sickness and absence rates, and clinical negligence.

‘Models of Care’ approach

More recently a ‘Models of Care’ approach has provided the basis for mental health workforce development in New Zealand (Ministry of Health 1996). This approach no longer sees professions in isolation, but gives consideration to the total skill mix available in the statutory and non-statutory sectors and is based on agreement about the value of multidisciplinary teamwork. It identifies the need for developing training standards and education to underpin the team approach in meeting consumer needs (Higgitt 2001). This approach involves a patient focus and user involvement. A similar approach is illustrated by the maternity lead carer model.

1.2.2 Educating and training the workforce

Educating and training the workforce is about improving the quality of the services delivered. It includes pre-entry, entry and post-entry education and training, and continuing professional development. Current models for educating the workforce are undergoing change in New Zealand, such as recognition of prior learning (for example, 30 percent of midwifery students have graduate entry). There is also debate about the introduction of graduate-entry medical education. Many health education programmes have moved from being diploma-based to degree-based over the last 10 years.

While major changes have taken place in the financing and provision of health care, the location and content of many health education programmes have undergone comparatively less change. The range of diseases seen on an inpatient basis is narrowing, and many important diagnostic problems are solved outside the hospital, so a greater emphasis on teaching nursing and clinical medicine could shift from inside to outside the hospital.

The impact of moving educational programmes out of hospitals is complex, and affects both the education and health sectors. It may decrease hospital overheads (for example, less of the slowdown effect in hospitals from having lots of students), but the increased co-ordination of training programmes could potentially reduce the productivity of teachers.

There has also been an expansion of training courses, particularly in mental health, although funding constraints affect the range available in other service delivery areas. The ability of health practitioners to access the training opportunities is sometimes limited by a shortage of staff, which precludes releasing staff for upskilling.
1.2.3 Managing the workforce

Managing the workforce occurs at two levels. The central agencies (Ministry of Health and regulatory bodies) set policy at the macro level, and the DHBs and other providers (public and private) deal with operational matters.

Activities undertaken by the Ministry of Health and regulatory bodies in New Zealand include:

- regulation of scopes of practice
- licensing and renewals
- funding for service delivery, and quality control through monitoring.

At a DHB or operational level, the following principles are important:

- establishment of a workforce database to meet strategic and operational requirements
- management and technical knowledge, and interpersonal skills of the managerial and supervisory staff
- assurance and maintenance of quality through adequate supervision
- adequate and stable compensation systems – this goes beyond salary to include paid training opportunities, and planned and systematic upgrading of pay and benefits through promotion, job enrichment and fringe benefits
- incentive systems supporting health goals – incentives must be balanced between activities focusing on prevention and primary care and an emphasis on curative care, which currently offers the greatest financial rewards
- career ladders lead to efficient use of workers – the ability to retain experienced workers protects the investment in their training, provides stability to the organisation and enhances morale (based on De Geyndt 2000).

The results of a quality programme of planning, training and managing the health workforce should be improved clinical outcomes and greater patient satisfaction. Patient care outcomes and improved health status should guide healthcare workforce decisions (De Geyndt 2000).

1.3 Questions

1. What is an appropriate approach to guide workforce development in the New Zealand health sector?
2. What is an appropriate timeframe for planning workforce development in the New Zealand health sector?
3. What workforce development strategies should be centrally driven?
4. What central support or co-ordination would assist workforce development at the operational level?
5. How do we improve benchmarking in New Zealand?