The New Zealand Health Workforce

A Stocktake of Issues and Capacity 2001
“Place stone on stone, and see the way, from one cairn to the next.”
The New Zealand Health Workforce

A stocktake of capacity and issues 2001
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Foreword

Stocktake 2001 provides a ‘snapshot’ of the New Zealand health workforce. It is based on the best data currently available. It also identifies the complex environmental factors that impact on the deployment of the workforce throughout the health sector. The report depicts the way the health workforce looks now and the issues the workforce reported to the Committee.

Various assumptions underlie the work of the Committee. A key assumption is that our health system and health workforce together represent a taonga which we must all value and nurture. Another is that the one constant in health care is the inevitability of change, but that informed debate and decision-making are the basis for constructive change and planned evolution of service delivery. A third assumption is that robust partnerships – for example, between health providers and the community, clinicians and managers, health and education sectors – are the basis not only of effective healthcare and workforce development, but also of a caring society on which health services depend. We are all in this together.

The Committee is now focusing on how the workforce needs to develop to meet the vision set out in the New Zealand Health Strategy. It is taking a person-centred approach, recognising that the needs of the person, whānau, and community must be the primary reference point rather than professional interests. It is focusing on the following areas as priorities for workforce development:

- the workforce implications of implementation of the Primary Health Care Strategy
- education to meet future health workforce needs
- building Māori health workforce capacity
- building Pacific health workforce capacity
- promoting a healthy hospital workplace environment
- building health and support workforce capacity for people who experience disability.

The Committee will release a discussion document setting out challenges, directions and options for the sector in mid July 2002 and undertake wide health sector consultation later in the year.

The Health Workforce Advisory Committee looks forward to working with health practitioners, health service providers and policy makers, and with the wider community, to address these challenges.

Prof Andrew Hornblow CNZM
Chair, Health Workforce Advisory Committee
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Executive Summary

This stocktake is the first report of the Health Workforce Advisory Committee (HWAC), which was established in April 2001. It is a preliminary assessment of the capacity of the current workforce, and issues that must be addressed to meet the objectives of the New Zealand Health Strategy and the New Zealand Disability Strategy. It is based on information provided to the Committee by the professional, regulatory and employing agencies of the health workforce itself. The Committee is interested in receiving feedback on the issues and questions raised.

To inform this report, a letter was sent to over 280 stakeholders requesting information on current workforce issues and concerns. Apart from this, no new information was sought. Existing sources of data have been used and the many limitations of this are identified. This process has highlighted the need to develop a standard for collecting, reporting and disseminating health workforce capacity information to the sector.

A key message from this report is that to achieve the vision for our health service, as outlined in the New Zealand Health Strategy and the New Zealand Disability Strategy, a major paradigm shift is required. This will impact on the roles of health practitioners delivering health services, the way health practitioners are educated and trained, and the way they are managed.

HWAC plan to release a second report in mid-2002 setting out directions and options for the health workforce development required to move towards the new paradigm. This later document will throw out challenges to the various stakeholders to make changes to the way the sector currently does things and to suggest options which may push the boundaries of past workforce practices.

HWAC are also seeking to facilitate collaboration between the key organisations involved in health workforce development within the health sector, including the Ministry of Health and District Health Boards New Zealand, and between sectors – the Ministry of Education and education providers in particular.

Health workforce planning and development

Workforce planning in New Zealand has had a chequered history over the last 25 years, with initial efforts to plan the medical workforce started in 1976 and extended to other groups in the early 1980s. These early efforts established annual data collections for the regulated health practitioners, and these collections continue. The health reforms of the 1980s and 1990s led to a decreasing emphasis on centralised workforce planning and a view that planning should reside with health sector employers, with the market ensuring optimal outcomes. Sadly, this was not a successful policy decision and the infrastructure and knowledge around workforce development was largely lost. Efforts to rekindle an interest by way of the Committee Advising on Professional Education in 1996 foundered.
There is now renewed interest in workforce planning and development in the health sector, both in New Zealand and internationally. The wider public sector is also exploring how initiatives such as globalisation and technological advances impact on workforce mobility and the requirements for ongoing professional development.

New approaches to workforce planning are emerging and gaining attention. For example, the ‘models of care’ approach considers the total workforce skill mix available for the delivery of quality health care and has a person-centred and patient-involved focus. It no longer sees professions in isolation but gives consideration to all workforce groups. It is oriented towards competencies and continuing skill and knowledge development, and requires responsiveness on the part of the practitioner to the person needing health services. HWAC intend to explore this approach as a basis to guide future work.

Prescriptive central workforce planning based on detailed estimation of the required numbers of individual practitioners is no longer adequate to address strategic issues. There is, however, a need to establish the level of responsibility for various aspects of workforce development. Some activities require central support, while others are more appropriately the responsibility of employers with support and co-ordination from a central unit. These issues require broad sector debate.

The New Zealand health and disability sector

The future direction for New Zealand health sector development is clearly signalled in the New Zealand Health Strategy. The Minister of Health has adopted seven key strategies for priority attention:

- Māori Health Strategy
- New Zealand Disability Strategy
- waiting times (medical, surgical and radiotherapy)
- diabetes incidence and impact
- inequalities
- Primary Health Care Strategy
- Mental Health Blueprint.

Significant population shifts predicted over the next 20 years have led HWAC to also consider the health of older people in terms of workforce development.

These strategies signal a shift in service delivery towards prevention and primary health care to meet the health needs of an increasingly ethnically diverse and ageing population. This raises questions about the competencies required to meet this new service direction, and the selection and education of the future health workforce. To enable this new direction, a significant reorienting of many existing health practitioners will be required. The concept of life-long learning will be a feature of the new paradigm.
The implementation process of the Primary Health Care Strategy is still unclear, but it is here that major innovative workforce practices and efficiency and effective gains could be achieved for the health sector. Clarity about what constitutes work as a ‘team’ is needed. Some groups – such as dietitians, psychologists and podiatrists – have the opportunity to provide increasing services in the primary setting, but current funding and governance structures do not readily facilitate this.

The strategies are relatively silent about secondary and tertiary health services, yet much of the health workforce is currently deployed in this sector and will continue to be so in the foreseeable future if recent trends continue. This has important implications for the availability of health practitioners with the appropriate skills to implement the strategies; for example, the integration of primary and secondary care.

Quality issues and legislation

Quality and ‘best practice’ are important to achieving improved health outcomes within capped budgets, as they emphasise efficient and effective health care delivery. There are a number of initiatives in varying stages of implementation which have associated workforce implications, including evidence-based practice and the use of guidelines, credentialling, clinical governance and the proposed Health Practitioner’s Competence Assurance Bill, due for enactment early in 2002. The Bill is intended to enable flexible workforce development, and regulatory bodies will be required to develop scopes of practice for practitioners.

The development of new institutions, such as the office of the Health and Disability Commissioner, over the last 10 years has improved consumers’ ability to address concerns and complaints about health service delivery. It has also led to a higher level of scrutiny of all health practitioners, and a fear of medico-legal risk that is detrimental to service delivery innovations.

Environmental trends

This report highlights environmental trends and issues that impact on the supply of and demand for health professionals, and that will ultimately drive health workforce changes. Globalisation, technology, labour costs, increased consumer knowledge and expectations, and the ageing and increasingly diverse population are likely to be the key drivers of change over the next few years.

Globalisation is leading to increased mobility of health practitioners, particularly highly skilled practitioners, who now face lower restrictions with increasing mutual recognition of qualifications between jurisdictions and increasing collaboration and internationalisation of standards for credentialling processes and training programmes. The question of the cultural competence of non-home-grown practitioners is of increasing importance. New Zealand has historically had a relatively high percentage of overseas-trained practitioners, but only recently have programmes been developed to address the associated cultural issues.
The New Zealand health sector knowledge management project, Working to Add Value through E-information (WAVE), has large but as yet unquantified implications for the health workforce. The gains in terms of integration and co-ordination between primary and secondary care may lead to a change in workforce skills in the longer term. In the short term, the programme may place heavy demands on providers to upskill the existing workforce to utilise and support the available technology. Other impacts of technology via new diagnostic techniques, advances in surgical techniques, drugs replacing labour-intensive treatment approaches and increased consumer knowledge and expectations will have a huge impact on the workforce over the next 20 to 30 years. Further assessment of the impact of technology development on the workforce is required.

The economic outlook for New Zealand will affect the future health status of individuals and the proportion of GDP spent on health. Increasing health care demands in an environment of financial restraint will lead to the development of innovative, effective and efficient health services. This may drive skill-mix adjustments and opportunities for substitution within the workforce.

**Education**

The education system is being refocused to take a more strategic approach to addressing the skills, knowledge and innovation that New Zealand needs. This will help facilitate changes to meet national needs, including those in the health sector. Funding is available to provide increasing support for Māori and Pacific peoples entering health practitioner education programmes, and increasing attention is being paid to criteria for entry into health programmes and the alignment of these criteria with processes for selecting students. Demographic shifts will also determine the number and profile of students choosing to enter health professions.

**Consumer expectations**

Consumers have increasing access to knowledge via the Internet, and a greater choice in terms of providers, and in recent years they have displayed increasing expectations of health practitioners. This is an appropriate development, driving a more person-centred approach to health services delivery. It has also led to a number of high-profile cases coming before the Health and Disability Commissioner as consumers become more aware of their rights and the appropriate quality of care.
Service delivery developments

The increasing complexity of patient conditions and increased throughput of patients in hospital settings require increasingly skilled health practitioners. Trends impacting on the health workforce include:

- decreased length of stay from 6.6 days in 1988/89 to 3.2 days in 1999/00
- increased day-case rates across all specialities
- increasing outpatient attendances
- increased activity in primary care settings
- a shift from care in hospitals to ambulatory and community-based settings
- new technologies and discoveries, which continue to increase our ability to prevent, diagnose and cure illness and injuries.

Recruitment

Recruitment issues occur at three points in the system:

- admission to health education programmes
- new graduate appointments in New Zealand health workplaces
- the appointment of experienced personnel, including those returning to work.

There appears to have been a decline in recent years in the number of new entrants to nursing programmes, although the reasons for this are unclear. There is also a well-documented need for increasing Māori practitioners across all health practitioner groups. Development of the Māori community health worker is seen as a major opportunity to develop by-Māori-for-Māori services.

Recruitment and retention issues are the result of a number of factors, including increasing globalisation and international shortages of health practitioners, and increasing health demands from ageing populations. These factors lead to increasing opportunities for skilled New Zealand-trained practitioners to gain overseas employment. High levels of student debt, along with well-paid overseas opportunities, are encouraging young doctors to leave New Zealand earlier than in the past. The length of overseas experience for recent graduates is unclear.

Retention

This is a major issue, with difficulties experienced across many health practitioner groups, particularly with regard to experienced workers. It is not confined to the public sector, although there is concern that the public sector cannot compete with the private sector in some areas.

Overseas work environments are attractive to New Zealand staff as they are perceived to provide improved education and career opportunities, better remuneration and working conditions.
Even where sufficient numbers of Māori are being trained (for example, in midwifery), the high expectations in the workplace cause retention issues such as ‘burn out’. This needs urgent attention by employers and provider organisations in order for Treaty of Waitangi obligations to be met.

**Workplace environment – ‘good employer issues’**

The legacy of the health sector reforms of the 1990s is still manifesting itself in the level of stress and instability, and erosion of morale and job satisfaction in the clinical workforce. Contributing factors identified in submissions to the Committee include workloads that are perceived to be unrealistic, decreasing numbers of staff coping with increasing throughput, and increasing expectations to extend work hours to absorb new clinically oriented responsibilities (for example, clinical audit, quality and risk management activities).

Certain areas and populations have specific issues. Rural health is an ongoing concern, and while initiatives have been put in place, these need evaluating because problems persist. The opportunities to develop teams and new ways of working in the rural sector may well lead to innovative changes in service delivery. The flow-on effect might be these changes are transferred urban practices.

**Workforce capacity**

Part II of the stocktake provides a snapshot of the over 100,000 practitioners who comprise the New Zealand health workforce. The capacity of and issues for each group of practitioners are summarised, and the groups are clustered to reflect areas of practice in line with the New Zealand Health Strategy.

This snapshot indicates that there are approximately 67,000 health practitioners supported by an estimated 30,000 support workers delivering services to New Zealanders. A further 10,000 alternative and complementary health workers also offer services directly to the public. Māori practitioners comprise 5 percent of the professional health workforce, and Pacific practitioners comprise 1.7 percent.

Medical practitioners and nurses collectively make up approximately two-thirds of the health practitioner workforce. These groups are increasing at a greater rate than the population growth and are contributing more time to work. Compared with 1990, a similar proportion of the medical workforce is working in the primary care setting in 2000 (39 percent). In contrast, an increasing proportion of the nursing workforce is now working in the community (23 percent compared with 16 percent in 1990).

Overseas practitioners continue to play a major and increasing role in the New Zealand workforce, comprising 35 percent of the medical workforce and 16 percent of the nursing workforce.
The mental health workforce has had major investment over the last few years, but the number of workers with competencies to deliver the ‘recovery’ approach is still a substantial issue. Recruitment and retention concerns for all mental health workers persist. Skilled workers generally prefer to work in urban locations. The ‘recovery’ approach has led to the development of new mental health consumer workers who support mental health service users in a variety of ways. There are also moves to develop a ‘generic’ mental health worker. These innovations may provide models for solutions to workforce issues in other service areas.

The disability workforce comprises two distinct groups: practitioners providing health services to disabled people, and support workers providing disabled people with assistance in their daily lives (for example, education and recreation). There are major difficulties recruiting support workers, and development of an appropriate education or training programme is important. Disabled people want more say about the services they receive, and more control over the services that are delivered.

The public health workforce has suffered from a low profile over the last few years, yet a strong public health workforce is crucial to delivering the New Zealand Health Strategy. The development of Māori at all levels and across all workforce groups is essential to improving health outcomes for Māori and to meet Treaty of Waitangi obligations. The development of Pacific community health workers is seen as crucial to the development of an effective public health workforce. Demand for the Pacific workforce to deliver services to the Pacific community continues to grow. In some cases there are health practitioners trained in their home countries who do not have registration to use these qualifications in New Zealand. The upskilling required to meet New Zealand registration standards needs further exploration, and appropriate courses need to be developed to enable these practitioners to work with their own people.

Issues for the technical allied health workforce are not unique, but are magnified by the relatively low profile of these professions prior to the recent serious shortage of radiation therapists. Issues for medical physicists and medical laboratory technologists centre on access to training opportunities, and recruitment difficulties in a buoyant international market.

This stocktake aims to identify the issues that impact on the development of the health workforce, and the drivers for change. Many of the issues identified cannot be solved by individual employers, or indeed, individual countries. Solutions need to be found collaboratively and successful innovations shared. Workforce issues are complex, and anxiety is created by challenges to traditional professional boundaries and roles. The present recruitment and retention issues also lead to institutions being challenged, boundaries blurred and tasks redistributed to ensure that effective health service delivery is maintained. Technology is likely to play an increasing role as skilled workers continue to be in short supply. If innovative solutions are to work, health practitioners need to be able to fulfil their career aspirations in a healthy workplace environment. Despite changes, health practitioners will continue to be central to the delivery of effective, efficient, quality, person-centred health care.
Introduction

The New Zealand health and disability workforce is an essential component of health service delivery, currently accounting for approximately 70 percent of the cost of delivering public health services. By international standards this workforce is highly skilled and knowledgeable, and is well equipped to deliver a range of health services across the primary, secondary and tertiary settings. Much of the workforce is regulated, but there are an increasing number of people providing health services outside the traditional regulated workforce groups.

Over the last eight to ten years the New Zealand health sector has undergone successive reforms, and the collection of accurate information on the health workforce has not been a priority. The New Zealand Health Information Service (NZHIS) has continued to collect information on behalf of the Ministry over this period. However, the Ministry has not seen itself as having a role in analysis and monitoring of information, apart from some analysis by the Clinical Training Agency (CTA) of the medical specialist workforce. This omission has been brought sharply into focus recently with increasing international shortages of various health practitioners. Shortages of medical radiation therapists, for example, have impacted significantly on service delivery. These shortages – along with an ageing population with increasing health care needs, best practice requirements, technology, treatment regimes, clinical pathways, hospital in the home, and primary and preventive care practices – makes it imperative that more attention is placed on the strategic development of the health workforce to meet health sector goals.

To address these workforce concerns, the New Zealand Public Health and Disability Act 2000 makes provision for a Health Workforce Advisory Committee (HWAC) (see Appendix 1 for the Terms of Reference agreed with the Minister of Health). The Committee, established in April 2001, comprises representatives from a range of sector interests and is answerable to the Minister of Health (see Appendix 2).

This stocktake report is the first activity of the Committee and has been undertaken under tight time constraints. It aims to establish a benchmark for measuring the capacity of the health workforce. It provides a preliminary overview of the current health workforce, and identifies issues that impact on the health workforce. The data included in this report are the best available through recognised sources.

Within the Ministry of Health a Workforce Advisory Group was also formed in May 2001, tasked with co-ordinating workforce initiatives that are being undertaken within the various Ministry directorates to ensure they are consistent with the New Zealand Health Strategy and the New Zealand Disability Strategy. District Health Boards New Zealand also have a workforce focus. HWAC works collaboratively with these groups (see Appendix 3).

The New Zealand Health Workforce 2001 is to be viewed as a working document to inform the Minister of current workforce capacity, and to inform Committee deliberations and consultation processes. It will be updated as new information becomes available. We invite readers to provide more accurate or recent information.
HWAC’s primary focus will be the ‘public’ sector workforce, or those working in government-funded areas. However, no special effort has been made to separate out the private sector workforce as there are difficulties distinguishing between public and private. Private hospitals provide public health services on contract, and most maternity and older persons’ care is publicly funded but carried out in what have historically been called private hospitals. In addition, many health practitioners work for more than one employer and many span the traditional public/private divide.

To inform this stocktake, the Committee wrote to a wide range of stakeholders (Appendix 4) with an interest in workforce issues, seeking input about current information sources and key concerns and challenges. This process elicited over 80 submissions (Appendix 5) and the information provided is included in this report. In addition, all recent reports on the health workforce were reviewed, along with current information from the annual workforce surveys undertaken with the purchase of annual practising certificates for the regulated workforce groups.

The report consists of two parts:

- **Part I** covers issues associated with the health workforce, including New Zealand’s experiences with health workforce planning, quality initiatives and legislation, environmental trends and issues, rural workforce issues, Māori workforce development, and Pacific workforce issues.

- **Part II** provides a profile of individual workforce groups. It includes a description of the practitioners, including numbers practising, education and training available and key issues identified in submissions to the Health Workforce Advisory Committee.

This report and subsequent consultation will inform the Committee’s next major task – preparation, currently underway, of a second report. This will review the directions and options for future development of the health and disability workforce required to meet health needs for the 21st century, signalled in the New Zealand Health Strategy and the New Zealand Disability Strategy.