STRATEGIC PRINCIPLES FOR WORKFORCE DEVELOPMENT IN NEW ZEALAND

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The Health Workforce Advisory Committee (HWAC) is an independent committee appointed by, and reporting directly to, the New Zealand Minister of Health. It provides the Minister of Health with strategic advice on the health and disability workforce

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## Contents

Introduction ................................................................................................................................. 1

### Strategic Principles for Workforce Development

- Equity and Appropriateness ............................................................................................... 6
- Strategic and Sustainable Supply ......................................................................................... 8
- Healthy Workplaces ............................................................................................................... 10
- Collaborative Practice .......................................................................................................... 11
- Effective Education ................................................................................................................ 14
- Stakeholder Involvement ...................................................................................................... 16

References ................................................................................................................................. 20

### Appendix One: The Context for Workforce Development

- Demographic Factors ............................................................................................................ 23
- Changes in Policy .................................................................................................................... 25
- Structural, professional and regulatory changes .................................................................... 27
- Changes in Practice ................................................................................................................ 28

### Appendix Two: The Health Workforce Advisory Committee’s Strategic Principles and its Strategic Priorities

### Appendix Three: Relevant Overarching Principles

- The New Zealand Health Strategy: Fundamental Principles ............................................. 33
- The New Zealand Disability Strategy’s Vision of a Non-disabling Society ...................... 35
- The Australian National Health Workforce Strategic Framework: Guiding Principles .......... 35

### Appendix Four: The Health Workforce Advisory Committee
INTRODUCTION

This paper sets down seven Strategic Principles that the Health Workforce Advisory Committee (HWAC) will use to guide its future approach to workforce development. These Strategic Principles will serve two functions. Firstly, they will underpin the advice HWAC provides in specific areas and for specific parts of the workforce. Identifying explicit principles to guide HWAC’s future work will enhance the Committee’s ability to be strategic in workforce development by placing emphasis on the outcomes we want such development to achieve, rather than the operational measures used to get there.

Secondly, HWAC will promote the Strategic Principles as a tool for all those involved workforce development. HWAC believes that having the Strategic Principles available as a reference will assist these stakeholders to reflect on their workforce development activities, and provide a common basis for different parts of the sector and professional groups to talk to each other about workforce issues.

In recent years, the issue of workforce development has become an increasingly central concern of planners, policy-makers and professional and stakeholder groups in the health and disability support sector. In 2003, HWAC reported that processes for workforce development had become characterised by, amongst other features, degraded planning and development infrastructure, siloed thinking, inadequate information, and unhealthy work environments (HWAC 2003). HWAC made a series of recommendations aimed at remedying this situation, divided into seven different priority areas,1 and identified several of these recommendations as key priorities deserving of immediate attention. HWAC’s attention has now largely turned toward addressing specific strategic issues facing the health and disability support sector.

In addition to HWAC’s work, several other organisations and structures have developed, or are currently developing or revising, strategies and plans with implications for workforce development. Some of these, such as the 2002 Mental Health (Alcohol and Other Drugs) Workforce Development Framework, largely predate HWAC, while others have been formulated since its creation. In particular, the overarching visions, principles and goals set out in The New Zealand Disability Strategy (2001) and The New Zealand Health Strategy (2000) establish a clear overall direction for the health and disability support sector. All aspects of the sector are expected to contribute to realising these strategies, including of course, the health and disability support workforce.

1 These seven areas were to: address the health workforce implications of the Primary Health Care Strategy, progress the development of healthy workplace environments, facilitate the evolution and further development of health workforce education, progress Māori health workforce development, progress Pacific health workforce development, facilitate evolution and development of the health and disability support workforce to better meet the needs of disabled people, and facilitate the enhancement of health workforce research and evaluation capability.
Building on The New Zealand Health Strategy and The New Zealand Disability Strategy are strategies and plans that set out specific actions that need to be undertaken to realise the goals set out in these documents. Some such plans relate specifically to the workforce, while others primarily concern particular populations, conditions or areas within the sector, but have important implications for the workforce. These include the Pacific Health and Disability Workforce Development Plan (2004), The Primary Health Care Strategy (2001), Achieving Health for All People: Whakatuki te Oranga Hauora mo ngā Tāngata Katoa (2003), the Health of Older People Strategy (2002) and work on the development of Raranga Tupuake: the Māori Health Workforce Development Plan. As well as work led by the Ministry of Health, other bodies undertaken their own strategic work on workforce development, such as District Health Boards New Zealand’s Future Workforce project and individual Workforce Action Plans.

HWAC is pleased to see workforce development receiving more detailed and considered attention from administrators, planners and policy-makers. While this issue has not been ‘resolved’, all parts of the sector are now actively engaging in debate around how we as a country should be developing our health and disability support workers.

However, it is also concerned that much of this action is being undertaken in siloes. Although specific sectors may be undertaking excellent work in their own areas, there has been comparatively little work on developing an integrated and strategic direction for the workforce as a whole.

Although HWAC recognises that the health and disability support sector is a diverse and complex one that ‘will not respond well to doctrinaire prescription’ (HWAC 2003), HWAC is concerned at this apparent lack of coordination. Not only may it be leading to unnecessary duplication of effort, but if different parts of the sector are not aligning their development activities then our workforce – taken as a whole – may not realise its full potential. If sectors and organisations are not talking to each other, it makes it difficult to develop cross-sectoral or inter-professional solutions to common problems, or use lessons or expertise from across all areas to develop the most effective approaches to workforce development. A well-functioning health and disability support sector requires all its different components to be working in broad alignment – including in their approach to workforce development.

At the same time, however, HWAC is not arguing for a single ‘one size fits all’ approach to workforce development. One of the defining features of the health and disability support sector is the diversity of its workforce. The issues facing the specialist tertiary medical workforce in a large urban hospital, for example, differ from those facing public health nurses in rural areas, which in turn differ from those facing other practitioners in NGOs or the unregulated workforce. What is needed or will work for one type of provider, worker or practice area may not be appropriate for another.
HWAC recognises a tension between its desire for an integrated approach to workforce development, and the need to recognise the distinctive nature, position and concerns of different parts of the sector. One way of dealing with this tension is through emphasising partnership and collaboration. HWAC firmly believes that effective and strategic approaches to workforce development must be based on active engagement between different disciplines, different groups of practitioners, and different employers.

An important prerequisite for such an integrated approach, however, is ensuring that all stakeholders have a common conceptual ‘language’ in which to discuss workforce development. The diversity of the sector means that one part may have difficulty understanding the relevance of the issues facing another, or why a particular workforce development strategy is needed. Without a common frame of reference, there is a greater likelihood that groups will concentrate on their superficial differences rather than their common underlying needs and goals.

One of the fundamental elements of developing a common frame of reference is the creation of unified principles to guide workforce development across the whole health and disability support sector. The Committee is concerned, however, that in New Zealand such principles do not appear to have been developed and explicitly stated. Specific workforce-related priorities, themes and actions recur throughout the documents discussed above. However, so far the underlying principles that are driving these measures have been largely left implicit.

The Strategic Principles set out in this document represent a first step in this direction. At this point, these principles only relate to HWAC’s own projects and strategies. However, the Committee hopes that they will prompt wider discussion amongst the health and disability support sector and lead to the development of a key set of agreed principles and outcomes for the sector. This, in turn, will lead to the fulfilment of the Health Workforce Advisory Committee’s overall workforce vision:

| The New Zealand health and disability support workforce will be person-centred, reflect the needs and health priorities of the people and populations it serves, flexible and responsive to changes in those needs, sustainable, and appropriately supported. |

2 HWAC is aware that some work is currently being conducted in the Ministry of Health on such issues, and sees the Strategic Principles and the Ministry’s work as complementary.
STRATEGIC PRINCIPLES FOR WORKFORCE DEVELOPMENT

These Strategic Principles for the development of the health and disability support workforce have been identified through the analysis of existing workforce-related plans, strategies and associated documents. The starting point for this work has been The New Zealand Health Strategy and The New Zealand Disability Strategy, and HWAC’s 2002 and 2003 Future Directions documents. HWAC has also included in its analysis other existing New Zealand workforce-related plans, strategies and associated documents, and further supplemented it by drawing on the National Health Workforce Strategic Framework developed by the Australian Health Ministers’ Conference.3

Rather than being specific actions or priorities, the Strategic Principles represent fundamental ideas about the environment and qualities needed to support a workforce that can effectively promote the wellbeing of the New Zealand population. As they are intended to be strategic and applicable across the entire health and disability support workforce, the principles set down here are broad in nature. HWAC believes that this is a virtue, as it allows the specific meaning of each principle to reflect the particular needs and context of individual areas and stakeholders within the overall health and disability support workforce.

The Strategic Principles have been drawn from HWAC’s perception of those principles that are already implicitly driving workforce action in the sector. They are not a criticism of any workforce-related plans or stakeholders. Rather, the principles discussed here are intended to provide a platform for promoting a strategic, integrated and collaborative approach to workforce development involving all parts of the sector.

HWAC accepts that fully realising these principles will take time; they are outcomes to work toward rather than aims that can be achieved tomorrow. Furthermore, their realisation will take significant effort and support from all parts of the sector, including providers, professional organisations, individual workers, and government bodies. This will be the case whether the principles are driving action in one area or across the whole of the health and disability support sector.

HWAC recognises that it will be particularly important to consider how smaller organisations, such as community providers, can be supported to realise these principles. Such organisations often operate under significant staff and financial constraints, and other bodies – particularly the Ministry of Health – will need to consider how they can appropriately support this part of the health and disability support sector.

HWAC has earlier identified the goal for workforce development as being ‘to recruit, train, employ, deploy and retain a health and disability workforce appropriate to meet the diverse needs of all New Zealanders in the short,

3 The principles in the Australian National Health Workforce Strategic Framework have been listed in Appendix Four.
medium and long term.’ (HWAC 2003) These principles complement this goal by providing an explicit basis for developing actions to fulfil this aim. Measures to achieve this goal, will, in turn, contribute to realising HWAC’s overall vision for the workforce:

The health and disability support workforce will be person-centred, reflect the needs and health priorities of the people and populations it serves, flexible and responsive to changes in those needs, sustainable, and appropriately supported.

The seven principles identified by HWAC are:

- **Equity and Appropriateness**
  All communities in New Zealand must be able to expect equitable outcomes from health and disability support services, have equitable access to services that are provided in the manner most appropriate to their needs, and be able to participate in the health and disability support workforce on an equitable basis.

- **Strategic and Sustainable Supply**
  Development of the health and disability support workforce must be strategic in nature, reflect identified priorities and issues for the population, and ensure that New Zealand possesses an appropriate, sustainable and affordable supply of health and disability support practitioners.

- **Healthy Workplaces**
  The health and disability support sector must be an attractive and healthy environment in which to work.

- **Collaborative Practice**
  The health and disability support workforce must be encouraged and supported to work in an integrated, interdisciplinary and intersectoral fashion.

- **Effective Education**
  The health and disability support workforce must have access to appropriate and relevant education and ongoing training.

- **Stakeholder Involvement**
  Effective health and disability support workforce development must be a collaborative process and involve a genuine commitment to participation and cooperation between all stakeholders, including consumers.

- **Information and Monitoring**
  Effective health and disability support workforce development requires capturing relevant information, the capacity to use this information, and effective monitoring and evaluation tools.
**Equity and Appropriateness**

All communities in New Zealand must be able to expect equitable outcomes from health and disability support services, have equitable access to services that are provided in the manner most appropriate to their needs, and be able to participate in the health and disability support workforce on an equitable basis.

The concept of equity is one of the most important and fundamental ideas driving action in the health and disability support sector. As *The New Zealand Health Strategy* states in discussion of its own principle of ‘timely and equitable access to health and disability services’:

‘This principle reflects the fact that fairness is a fundamental value for most New Zealanders, and the health sector must ensure that New Zealanders with similar health conditions are able to achieve similar outcomes.’ (Minister of Health 2000)

It is important to note that the concept of equity does not involve treating all people and communities in an identical fashion, but rather adopting courses of action that lead to equal health outcomes for all people. According to Whitehead and Dahlgren (1991):

‘…the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or eliminate those which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating opportunities for health and bringing health differentials down to the lowest levels possible.’ (cited in Mahoney et al 2004)

Strongly linked with the concept of equity is that of appropriateness: to as great an extent as is practical, health and disability support services should be delivered in a manner that is most effective at serving the needs of those who use them. This principle is embodied in the notion of a ‘patient-centred’ workforce, which HWAC has previously stated should underpin workforce development. Such an approach starts with considering the needs of people and populations and identifying what sort of workforce is most appropriate for meeting those needs (HWAC 2002). Similarly, it is important that all healthcare and support organisations themselves observe this principle as far as practical.

In terms of the workforce, the principle of Equity and Appropriateness has two main dimensions. The first of these is ensuring that practitioners have the requisite skills to ensure equitable outcomes and appropriate services for the population, and promoting models of practice that are geared towards meeting the needs of specific populations. For example, ensuring that the health and disability support workforce practises in a culturally safe manner, identifying what skills practitioners need in order to promote self-management approaches for people with chronic conditions, or developing specific practice
roles and new modes of delivery to meet the needs of particular communities such as new migrants or rural populations.

The second aspect involves ensuring that the health and disability support workforce is representative of New Zealand’s diverse population. As Betancourt et al (2003) point out in a discussion that can be extended beyond ethnicity:

‘Health care systems and structural processes of care are shaped by the leadership that designs them and the workforce that carries them out. From this organisational standpoint, one factor that impinges on both the availability and acceptability of health care for members of minority racial/ethnic groups is the degree to which the nation’s health care leadership and workforce reflect the racial/ethnic composition of the general population.’ (cited in Minister of Health 2004)

Research has demonstrated, at least with regard to ethnicity, support for the idea that increasing the representation of marginalised groups in the workforce has the potential to increase health outcomes for people from such communities (Cooper and Powe 2004). Although it may not be sufficient by itself, promoting equitable participation by groups that are currently under-represented in the workforce is not only a moral action but may also contribute significantly to addressing disparities in health outcomes.

The principle of Equity and Appropriateness is apparent in many of New Zealand’s workforce-related official documents. One of the most common examples of this is the well-recognised need to develop the Māori and Pacific health and disability support workforce. *The New Zealand Health Strategy* identifies fostering and supporting Māori health workforce development as a key objective for the sector, HWAC has previously identified progressing Māori and Pacific health workforce development as key priorities for workforce development (HWAC 2003), and *The Pacific Health and Disability Workforce Development Plan* and upcoming *Raranga Tupuake: the Māori Health Workforce Development Plan* set out specific initiatives in this area.
Strategic and Sustainable Supply

Development of the health and disability support workforce must be strategic in nature, reflect identified priorities and issues for the population, and ensure that New Zealand possesses an appropriate, sustainable and affordable supply of health and disability support practitioners.

Unsurprisingly, the principle of Strategic and Sustainable Supply is one of the strongest themes running through existing workforce development documents. If the visions, priorities and measures set down in documents such as The New Zealand Health Strategy and The New Zealand Disability Strategy, The Primary Health Strategy or the Health of Older People Strategy are to be realised, they will require an appropriate supply of appropriately trained practitioners. Initiatives for workforce development need to take account of these documents and ensure that they are reflecting the skills needed to fulfil those visions. Similarly, local-level workforce development plans need to be informed by documents such as DHB Health Needs Assessments that identify priorities for local communities.

A strategic approach to workforce development means more, however, than simply referring to other strategies and ensuring that the current workforce is appropriately skilled to address current needs and priorities. Adopting a strategic approach also entails taking a long-term view of workforce development, planning to address issues before they become embedded and difficult to resolve, and ensuring that initiatives and actions are sustainable over time. This does not mean ignoring issues of immediate concern. It is important, however, that account is taken of the long-term effects and implications of actions, and that short-term solutions do not become entrenched when they may not be the most effective or sustainable solution.

As an example, New Zealand has a high proportion of overseas-trained health professionals. This does have positive – or at least, not negative – aspects. Almost all countries use overseas practitioners to address gaps in their workforce, and those trained in other countries may have specific skills or areas of expertise that are in short supply in New Zealand. Some may be particularly useful in, for example, ensuring the availability of appropriate health services for specific ethnic communities. However, relying on overseas-trained practitioners for such a large proportion of its workforce does make New Zealand particularly susceptible to fluctuations in the global health workforce ‘market’ and shifts in immigration flows. It is therefore possible that this situation will create problems over the long term.

It may not be possible for New Zealand’s health and disability support sector to be fully self-sufficient in terms of its workforce. We do, however, need to ensure that we have a sustainable supply of practitioners. This should involve consideration of how to recruit people into health and support careers and how to retain them in the sector once they have trained. Similarly, although

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4 See, for example, HWAC 2005; Aiken et al 2004.
there may always be practitioners who choose to leave New Zealand for a time, we should not neglect consideration of how we can attract such workers back to the country.

Ensuring an appropriate and sustainable supply of practitioners is not, however, simply about ensuring that New Zealand has a certain number of practitioners and attracting or training more where there is a shortfall. Although this is certainly an aspect of the principle, it is also about ensuring effective use of the practitioners that we do have, and developing new practice roles and refining existing ones to appropriately address the changing demographic, policy, structural and practice contexts in which the health and disability support workforce operates.

Dealing with an emerging issue or a change in context does not automatically require new ways of approaching workforce activity and development – change simply for change’s sake is something that should be avoided. However, it is important that when innovation is required, work environments are conducive to such moves. Barriers to this can include cultural factors such as patch-protection and competition between groups of professionals, or more practical issues such as the training and resources required to implement new initiatives. Similarly, developing and refining new workforce measures has the potential to cause disruption to existing services if it is not effectively implemented.

Effective change management is thus also a critical element of the principle of Strategic and Sustainable Supply. Development of innovative solutions to workforce issues must be accompanied by ongoing and appropriate support measures to both minimise disruption to the existing work environment and reduce barriers. Similarly, it is important that appropriate monitoring and evaluation systems are put in place to ensure that new measures are effectively delivering their intended outcomes.
Healthy Workplaces

The health and disability support sector must be an attractive and healthy environment in which to work.

This principle represents the idea that the health and disability support workforce should be working in environments that are themselves healthy. Although there is no single unified conceptual model around the idea of ‘healthy workplaces’, Lowe (2003) states:

‘Research … converge[s] around the importance of supporting employees to be effective in their jobs in ways that promote, not compromise, their health. The ingredients include leadership that values employees as key assets, supportive supervision at all levels, employee participation, job control, communication, opportunities to learn, and a culture that gives priority to work-life balance and individual wellness.’

This principle thus covers more than simply ensuring physical health and safety, but includes social, emotional, cultural and organisational elements as well. This is an important issue for all workplaces. A major strand of the Department of Labour’s current Future of Work programme concerns the promotion of work-life balance and the vision of the Workforce Health and Safety Strategy to 2015 is one of ‘Healthy People in Safe and Productive Workplaces … [where] “Healthy” encompasses physical, mental and social wellbeing’ (Associate Minister of Labour 2005).

The New Zealand Health Strategy identifies the development and implementation of healthy workplace programmes as a key objective for the sector, and the Australian National Health Workforce Strategic Framework has as its third principle:

‘All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration.’ (AHMC 2004)

HWAC has previously identified the development of healthy workplaces as a key priority for workforce development – particularly given concerns regarding the recruitment and retention of practitioners in the workforce (HWAC 2003). Ensuring a positive working environment will enhance the ability of the New Zealand health and disability support sector to keep the workforce we have and attract new people into such careers. HWAC is currently producing a set of national guiding principles to provide a framework for promoting healthy working environments throughout the health and disability support sector.
Collaborative Practice

The health and disability support workforce must be encouraged and supported to work in an integrated, interdisciplinary and intersectoral fashion.

The principle of Collaborative Practice, in which practitioners are able and supported to work across discipline, setting and sector boundaries, is a key concept in modern approaches to health and disability support. There exists increasingly strong recognition that traditional ‘siloed’ approaches, in which both different parts of the sector (such as primary health, secondary health and mental health) and different groups of practitioners within these environments operate largely in isolation from each other, are not the best way to address the health and support needs of people and communities.

Similarly, there is increasing recognition that ‘health’ is a complex and multifaceted concept that requires a more holistic view than may have traditionally dominated Western approaches. For example, Durie’s whare tapa wha model conceives of health as a house composed of four walls: te taha tinana (physical) and te taha hinengaro (mental), but also te taha wairua (spiritual) and te taha whānau (family/community) (Durie 1994). Such models point to the need for a sector and workforce that acknowledges and is capable of addressing all these interrelated dimensions.

The Health Workforce Advisory Committee supports the increasing integration of health and disability support services, and HWAC has already stated that development of the health and disability support workforce must be considered within the context of integrated service delivery:

‘the boundaries between the workforces delivering health services and social support are increasingly blurred, and new approaches to workforce development acknowledge this continuum and emphasise interdisciplinary and intersectoral collaboration. Often no one practitioner has the full set of competencies to meet an individual’s needs, and teams of practitioners with a variety of competencies are best placed to ensure needs are met.’ (HWAC 2002)

In addition to integrating activities between settings and disciplines, the principle of Collaborative Practice also encompasses the importance of intersectoral action. The fact that many of the most important determinants of individual and community wellbeing lie outside the classically defined ‘health’ sector is well-recognised. In the same vein, a 2002 stocktake identified that

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5 It should be noted that the ‘spiritual’ aspect of health does not necessarily imply reference to organised religion. In their 2000 report to the Ministry of Health Hua Oranga: A Māori measure of mental health outcome, Kingi and Durie described four possible dimensions of taha wairua: ‘dignity, respect’, ‘cultural identity’, ‘personal contentment’ and ‘spirituality (non-physical existence)’.
6 See, for example, National Health Committee 1998; Ministry of Health 2003; Public Health Advisory Committee 2004b.
the development of just under a quarter of all strategies that affected health sector funders and providers had been led by agencies outside the health sector (Ministry of Health 2002a). To fully address the needs of the New Zealand population, practitioners need to work not only with other professionals and other official agencies (e.g. central government departments and ministries), but also local government and directly with communities.

Similarly, disability support is an area that is intrinsically intersectoral. The New Zealand Disability Strategy, for example, discusses the need for action by a variety of bodies from a variety of sectors to achieve its goals, and explicitly talks about creating a non-disabling society. Action to address the needs of people with disabilities must occur across all spheres of life, and may have little to do with tightly defined ‘health’ services.

Given these qualities, it is vital that the health and disability support workforce as a whole is capable of working across and with other sectors. For some groups within the workforce – such as practitioners of tertiary medicine – this principle may be less relevant than others. For large sections of the workforce, however, it has never been more relevant. For example, the ‘new’ public health’s intersectoral approach requires practitioners to work across a wide variety of different agencies, disciplines and sectors – many of whom have very different understandings of health and wellbeing (Public Health Advisory Committee 2004a). Similarly, intersectoral action has been identified as key to reducing inequalities in health outcomes (Ministry of Health 2002b).

The principle of Collaborative Practice is particularly important with regards to the primary health care area. Part of the philosophical cornerstone of The Primary Health Care Strategy is that effective care requires coordinated and integrated action both inside and outside the health and disability support sector. This includes a clear commitment to a multidisciplinary model of primary care, and increased coordination between the primary health and secondary health, public health, disability support and mental health areas. The Primary Health Care Strategy also explicitly states that Primary Health Organisations, along with DHBs, are expected to ‘participate in wider intersectoral activities that aim to address the social, cultural, and economic causes of ill health’ (Minister of Health 2001).

Another workforce-related document that places particularly strong emphasis on Collaborative Practice is Te Tāhuhu – Improving Mental Health 2005-15: The second New Zealand mental health and addiction plan. This document identifies linking with primary health care and cultivating effective partnerships with agencies outside the mental health and addiction area as key challenges for effective action in this area.7

Given this emphasis on increased coordination, integration and intersectoral action, it is important that the workforce is actively and appropriately

7 An action plan to address the challenges identified in Te Tāhuhu is currently being developed.
supported to work in this manner. Truly collaborative practice, whether it is between disciplines, between settings or between entire sectors, represents a significant departure from traditional approaches and require new skills and appropriate resources.

Some parts of the sector – particularly NGOs and community providers – have a longstanding tradition of collaboration with people and organisations both inside and outside the sector. Others, though, will require significant support to reorient their practice. While HWAC strongly supports developing a health and disability support sector underpinned by collaborative practice, it is unfair to place such expectations on the workforce without providing initiatives and resources to assist what will be a significant shift in both culture and practice.
Effective Education

The health and disability support workforce must have access to appropriate and relevant education and ongoing training.

Many of the principles discussed so far in this document refer to the need for New Zealand’s health and disability support workforce to be appropriately trained and educated. The pivotal position of education makes it important to recognise this as a separate principle; as HWAC has noted, ‘the education sector and its interface with the health sector are crucial to achieving a workforce responsive to … new directions’ (HWAC 2003). The current Statement of Tertiary Education Priorities also recognises this, and explicitly identifies addressing the education needs of the health workforce as a key priority for the tertiary education sector (Minister of Education 2005).

The principle of Effective Education firstly refers to the need to ensure that education programmes and ongoing vocational training reflect both the needs of the workforce and the principles outlined here. Both institution-based education and workplace-based vocational training need to be relevant to the experiences and activities expected of health and disability support practitioners, such as working in multidisciplinary teams and the need to practise in a culturally safe and person-centred manner.

Similarly, the introduction of new practice roles and service delivery models needs to be accompanied by discussion of the education and training needed to support such roles and models, and the development of appropriate programmes to meet these needs. Whether focused on supporting new roles or the changing needs of existing ones, such discussion needs to not only cover course content, but also the process of teaching and learning – including the exploration of new settings and methods of delivery for education and training (HWAC 2003).

Just as important as ensuring the availability of appropriate education and training, however, is supporting the ability of practitioners to access these programmes. Those responsible for funding the workforce must ensure that sufficient resources are available for those in the workforce to take up opportunities to develop their skills and competencies. Conversely, issues such as portability of qualifications, opportunities for staircasing between qualifications, and recognition of prior learning and experience arrangements, need to be engaged with by those involved with education and training.

It is also important to emphasise that particular parts of the workforce will have very different education and training needs. In some parts, this principle will refer to skills specific to clinical practice. In other parts of the sector, however, a priority may be ensuring that the workforce has access to basic literacy, numeracy or ESOL (English for Speakers of Other Languages) programmes.

One of the most important aspects of the Effective Education principle is tied strongly to that of stakeholder involvement: realising this principle requires the
education sector and the health and disability support sector to work closely together. The two sectors have differing pressures, must deal with different policy regimes, and involve different (though intersecting) stakeholders. Consequently, developing appropriate education programmes and patterns will require the existence of strong links between educational bodies, professional and regulatory bodies, and those who employ the health and disability support workforce. The closer the links between these stakeholders, the greater the ability of education providers to develop programmes relevant to the needs of the workforce, and the more realistic will be the expectations of the health and disability support sector.
Stakeholder Involvement

Effective health and disability support workforce development must be a collaborative process and involve a genuine commitment to participation and cooperation between all stakeholders, including consumers.

The principle of Stakeholder Involvement is a clear and unambiguous part of best practice approaches to public decision-making in New Zealand. The idea that those affected by any decisions should have input into the processes whereby they are made is an established principle not only within the health and disability support sector, but in all areas of publicly-funded activity.

HWAC fully supports this, and believes that effective workforce development requires an environment in which all stakeholders have the opportunity to contribute to identifying priorities and proposing solutions. As The New Zealand Health Strategy points out, such an approach to decision-making will have many benefits, including ensuring that decisions are based on appropriate knowledge and evidence, and that they enjoy a level of acceptability and legitimacy that makes them sustainable in the long-term. Similarly, the State Services Commission (1999) has noted in reference to involving stakeholders via consultation on government policy, that:

‘consultation has the potential to improve the quality and effectiveness of policies, to enhance responsiveness to citizens, and to strengthen the legitimacy of final decisions.’

When applying this principle to workforce development, however, it is particularly important to note that the workforce itself constitutes a stakeholder group in the health and disability support sector. As well as ensuring input from local communities and those who experience need for services, approaches to addressing workforce issues must include input from the workforce itself.

Precisely how stakeholders should be involved in workforce development will vary significantly depending on the nature of a particular issue, the stakeholders in question, and even the structure and philosophy of particular organisations. Approaches can extend from consultation, to the establishment of reference or expert advisory groups, to allowing representatives of particular stakeholders full participation in decision-making around workforce development.

However this principle is realised, a critical aspect is a genuine commitment to equitable participation. All stakeholders must be willing to engage in good faith with those processes that have been established for involvement, and an acceptance that this will likely require compromise by all parties. Of course, ‘genuineness’ is an inherently subjective quality that is difficult – if not impossible – to measure. However, HWAC would like to stress that it believes there is a strong moral obligation implicit in this principle to accept
the results of ‘fair’ processes and for stakeholders to be willing to listen to and engage with the positions of those with whom they may not initially agree.
Information and Monitoring

Effective health and disability support workforce development requires capturing relevant information, the capacity to use this information, and effective monitoring and evaluation tools.

Just as the concept of evidence-based practice is becoming increasingly influential in the health and disability support sector, so should workforce development plans and initiatives be based on high-quality evidence. As HWAC has previously stated: ‘The basis of all planning is the availability of good data … Information gaps need to be assessed and remedied in a consistent way’ (HWAC 2002). Similarly,

‘Research and evaluation are necessary to encourage and take advantage of innovation and to initiate and guide service and workforce redesign and improvement. Research in these terms should be seen as a core organisational function such as business planning, financial planning, IT development, and human resource management.’ (HWAC 2003)

At the other end of collecting information on which to base action is the need for effective monitoring arrangements to ensure that these actions are achieving these aims.

The most fundamental aspect of this principle is the need to have information available; data on the health needs of populations and communities, data on the characteristics of and trends within the health and disability support workforce, and data on the effectiveness of particular roles and workforce interventions. This involves being clear about what issues are important in a given workforce context, identifying what data needs to be collected to understand these issues, and ensuring that suitable processes and tools are in place to gather this information. It should be emphasised here that data refers to both qualitative and quantitative information – each form of knowledge has its own strengths and weaknesses, and effective workforce development should be based on both.

Information is, however, only useful if people actually have the capacity to use this information. Collecting, analysing and interpreting information can be a difficult and labour-intensive task requiring a significant investment of time and expertise, and it is not always clear that those who are expected to use this information have such resources available. Thus, the second aspect of the Information and Monitoring principle is the need to ensure that the collection of information is matched by the availability of capacity to use it.

This does not necessarily mean that all those involved in workforce development need to individually possess the requisite skills and resources to analyse information, but rather that they need to have some way of accessing...
this capacity. This may involve directly employing appropriately skilled individuals. However, it can also be achieved through participating in information-sharing fora and networks, or building formal links with other institutions that do possess such capacity. This may be the most effective way for smaller organisations and providers to realise this principle.

Finally, it is important to avoid situations in which information becomes an end in itself. When collecting and using information – and particularly in the development of ongoing monitoring arrangements – it is important to remember that the intent of information collection is to enhance the outcomes and experiences of those who use health and disability support services.
REFERENCES


APPENDIX ONE: THE CONTEXT FOR WORKFORCE DEVELOPMENT

Workforce development must be informed by discussion of the challenges, issues and objectives facing the health and disability support sector as a whole – issues that are subject to significant change over time. Demographic shifts, movements in wider workforce and lifestyle patterns, the effects of new sectoral structures and policies, developments in technology, changing understandings of ‘wellness’ and many other factors all have implications for the manner in which health and disability support workers must practise and should be organised. To quote Australia’s National Health Workforce Strategic Framework:

‘Health systems are always in a constant of evolution and this means that the environment in which the health workforce works and develops is complex and ever changing.’ (AHMC 2004)

The factors that influence the health and disability support workforce can be roughly divided into four broad categories: demographic, policy, structure and regulation, and practice.

In addition to the broad trends discussed below, resource constraints can have a significant impact on workforce development. Determining and allocating available resources is a highly complex process that occurs at multiple levels in and outside the sector and that will always be open to question and debate. However, both the quantum and methods of funding available to decision-makers will have an impact on the ability of the sector to undertake effective workforce development.

Demographic Factors

Demographic factors affect the workforce on two levels. Firstly, the demographics and living patterns of society and particular communities impact significantly on the type and mix of needs that the health and disability support sector has to address and the way in which services need to be provided. Increasing life expectancy in a population, for example, is often associated with an increase in the ongoing incidence of chronic conditions in that population. Similarly, the increasing urbanisation of New Zealand’s population raises questions around how best to deliver sustainable services to rural communities that are becoming smaller and more geographically isolated. Secondly, however, characteristics of and shifts in the nature of the workforce itself create their own issues that workforce development plans and strategies must address.

One of the greatest challenges currently facing the health and disability support sector is the ageing nature of New Zealand’s population, stemming from a combination of increases in life expectancy and decreasing birth rates. By 2021, the median age of the New Zealand population as a whole is expected to have increased from approximately 35 in 2004 to 40 years in 2021 and 45 by 2045 – although this will vary significantly between particular ethnic groups (Statistics New Zealand 2004). Table 1 shows this change
being experienced most strongly amongst the New Zealand European and Asian populations, with their average age will grow from 36.9 to 44.3 and from 28.2 to 36.2 respectively between 2001 and 2021. In contrast, the average age of New Zealand’s Māori and Pacific populations will grow from 22.1 to 26.4 and 21.4 to 23.7 over the same period.

Table 1: Projected Age Distribution of Ethnic Groups - 2001(base) and 2021 (Taken from Statistics New Zealand 2005)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Projected Age Distribution (%)</th>
<th>Median Age (years)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-14</td>
<td>15-39</td>
</tr>
<tr>
<td>NZ European</td>
<td>21</td>
<td>34</td>
</tr>
<tr>
<td>Māori</td>
<td>37</td>
<td>40</td>
</tr>
<tr>
<td>Asian</td>
<td>23</td>
<td>48</td>
</tr>
<tr>
<td>Pacific</td>
<td>38</td>
<td>40</td>
</tr>
<tr>
<td>Total Population</td>
<td>23</td>
<td>36</td>
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<th>Ethnicity</th>
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<td>NZ European</td>
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<tr>
<td>Māori</td>
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<tr>
<td>Asian</td>
<td>21</td>
<td>36</td>
</tr>
<tr>
<td>Pacific</td>
<td>33</td>
<td>39</td>
</tr>
<tr>
<td>Total Population</td>
<td>18</td>
<td>32</td>
</tr>
</tbody>
</table>

This ageing profile will result in increased demand for health and disability support services, and require significant change in the way services for older adults are planned, funded and delivered (Associate Minister of Health and Minister for Disability Issues 2002).

In addition, the health and disability support workforce – as with the rest of the New Zealand workforce – will itself be affected by this ageing trend, leading to increased numbers of practitioners seeking retirement or alternative working arrangements that involve only part-time practice. This is particularly an issue given that the health and disability workforce generally has a comparatively older age profile than the New Zealand workforce as a whole. Recent research by the New Zealand Institute of Economic Research suggests that, even under a conservative scenario, these factors will combine to cause a significant shortfall of health practitioners; according to these estimates the size of the overall workforce will need to increase by 11% between 2001 and 2011, and 28% by 2021 simply to maintain existing practitioner-population ratios (NZIER 2004). Under a worst-case scenario the needed increase by 2025 could be as high as 42%.

In addition, New Zealand is becoming a more ethnically diverse country. Although there are exists debate around the collection and analysis of
ethnicity data, official models predict that by 2021 people identifying as Māori are projected to make up 17% of the total population, Pacific peoples 9%, and the Asian population 15%, up from 15%, 7%, and 7% respectively in 2001 (Statistics New Zealand 2005). This growing diversity raises significant issues for the health and disability support sector as existing ethnic disparities in outcomes and different patterns of disease become more apparent and new issues, such as the distinctive needs of new migrant communities, increase in importance. It also points to a need to develop a workforce that is representative of this increased diversity.

One reason for this increased diversity is increased migration, as society, economy and culture in all countries becomes increasingly globalised. However, globalisation also has direct workforce implications. Throughout the world, previous barriers to travelling, living and working in different countries are generally being lowered – although the specific situation for health and support professionals varies between countries and occupations. Furthermore, there currently exists a worldwide shortage of health professionals, with health and disability support workers being in high demand internationally. Individual health and disability support systems are therefore increasingly required to compete with each other in an international market to attract a suitably skilled and sizeable workforce.

Relying on practitioners trained in other countries to cover gaps in the health and disability support sector has important implications. For example, it means that developing a working environment that is attractive to workers is of key concern in ensuring an effectively staffed sector. The ‘poaching’ of health professionals from developing countries by the developed world also raises important ethical issues.

The major effect of all these changes in terms of workforce will be a need to concentrate on increasing recruitment and retention of the health and disability support workforce. As our population ages, we are likely to experience increasing demands on health and disability support services. At the same time, unless we change our approach to workforce issues, the available supply of workers to provide such services will not be able to keep pace with this demand.

**Changes in Policy**

As well as these shifts in the nature of populations and associated health needs, the policy environment that governs the health and disability support sector impacts on the workforce. Policy documents create, either explicitly or

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10 It should be noted that these figures include people who identify with more than one ethnic group. This diversity will be even more apparent within the younger population – including the younger (15-39 years) end of the workforce, where proportions in 2021 are expected to be 20% Māori, 16% Asian and 11% Pacific (Statistics New Zealand 2005).

11 See, for example, Buchan and Calman 2004; Joint Learning Initiative 2004.

12 See, for example, Buchan et al 2003; Patel 2003; World Health Organization Regional Office for the Western Pacific 2004.
implicitly, expectations about how the workforce should be practising and the key priorities it needs to be geared to address.

Since 2000 and 2001 respectively, *The New Zealand Health Strategy* and *The New Zealand Disability Strategy* have been the guiding strategic documents for New Zealand’s publicly funded health and disability support sector. These strategies set out an overall direction for the sector and identify key high-level priorities for action. Further central government documents, such as *The Primary Health Care Strategy*, develop this vision into actions and priorities for particular population groups, conditions or parts of the sector.

One of the most challenging aspects of the policy environment that has developed in recent years is the promotion of a population health approach that incorporates an increased focus on addressing the determinants of health. It is well-recognised that many of the most important influences on the wellbeing of individuals and communities are located outside what is traditionally thought of as the health sector. Figure 1 below presents these determinants as layers of influence:

**Figure 1: The Determinants of Health**

![Diagram of the Determinants of Health]

Source: Dahlgren and Whitehead, cited in Public Health Advisory Committee 2004b.

Repositioning health practice and services to take account of this, along with action based in those sectors, therefore has the potential to reduce people’s need for secondary and tertiary health services. This is intended to benefit both individuals and service providers, as post-primary interventions are often not only traumatic for the people who need them, but also highly resource-intensive to provide.\(^\text{13}\)

\(^{13}\) For example, a 2002 United Kingdom Treasury review estimated that a ‘fully engaged’ approach incorporating significant emphasis on addressing the determinants of health could
The policy regime around health and disability support services also now places more explicit emphasis on addressing inequalities. Irrespective of how ‘health’ is measured, there are specific groups in New Zealand, defined by socioeconomic status, ethnicity, gender and other factors, that consistently experience lower health outcomes than the rest of the population (Ministry of Health 2002b).

The New Zealand Health Strategy positions addressing inequalities as a key concern by establishing ‘an improvement in the health status of those currently disadvantaged’ and ‘timely and equitable access for all New Zealanders’ as fundamental principles that need to be reflected in and across the health sector (Minister of Health 2000). Similarly, The New Zealand Disability Strategy sets forth a vision of a society where ‘disabled people are treated equitably’ and notes important socio-economic and ethnic disparities in the access and use of support services (Minister for Disability Issues 2001). The Ministry of Health’s Reducing Inequalities in Health work provides a toolkit to assist the promotion of equitable health outcomes.

Structural, professional and regulatory changes

The organisational structure of New Zealand’s health and disability support sector has undergone significant restructuring in past decades. Although the pace of structural change has slowed considerably in the past five years, the health and disability support workforce is still dealing with the legacy of rapid and dramatic restructuring during the 1990s. Similarly, the new institutions that marked the end of this period are still relatively new, and may continue to experience something of a ‘settling in’ phase over the near future. In the primary health care sector in particular, practitioners must deal with both relatively new District Health Boards and the recently implemented Primary Health Organisation (PHO) model.14

Recent years have also seen major changes within groups of health workers. Many groups of practitioners are developing new roles that either expand their practice into new areas, or represent an increasingly specific focus on sub-specialist areas. In addition, the passage of the Health Practitioners Competence Assurance Act 2003 has impacted significantly on the regulation of health practice, establishing regulatory bodies for some professions that previously did not have official bodies, formally introducing the concept of scopes of practice and new standards for competency assurance, and explicitly making patient safety the prime concern of workforce regulation.

There has recently been increased debate and discussion over issues of skill transfer and what tasks are considered appropriate for particular practitioners to perform. The most visible of these issues in recent times has been the extension of prescribing rights to new groups within the health workforce.

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14 It should be noted that the shift to PHO structures was not compulsory, although there exist(ed) strong incentives to move to this model of service delivery.
Considering such issues may reveal new and innovative ways of providing high-quality support and care. However, it also raises complex and sensitive questions around professional boundaries, and has the potential to cause tension both between and within groups of practitioners.

Changes in Practice

While the above changes affect the context in which the workforce practises, the workforce also faces issues stemming from changes in the interventions it uses and what constitutes ‘best practice’ care and support. Although the health sector has long been characterised by rapid technological and therapeutic advancements and changing approaches to practice, we are arguably entering – or even already in – a period in which the pace of such change is unparalleled. Advances in such areas as genetics, pharmaceuticals, and communications technology all have significant potential to enhance health outcomes or develop new approaches to managing and delivering health and disability support services.

Practice and technology changes create many issues for the health and support sector and the workforce. Firstly, there is a need to ensure that practitioners keep up to date with important advances in their field. Furthermore, the availability of such interventions can create pressure to provide such interventions when their use may not be justified or sustainable – especially in an environment of inevitably constrained resources. At one level, the workforce itself may be creating this pressure through, for example, increasing sub-specialisation in many disciplines. At another, as information about potential interventions becomes more accessible and widespread, professionals may face increasing demands for specific therapies from the people they treat and support.

This second level raises the more general issue of the rise of the ‘empowered consumer’ in which people are becoming more active participants in their own care rather than passive recipients of interventions. This raises questions around the appropriate role of health and support practitioners in such a relationship. A prominent example of this is in the area of complementary and alternative health (CAM) therapies, with approximately one in four New Zealand adults using CAM therapies at least once a year (MACCAH 2004). Recognising this, the 2004 report of the Ministerial Advisory Committee on Complementary and Alternative Health (MACCAH) recommended that further research into integrating biomedical and CAM practices be supported, and that attention be paid to including elements of CAM in health education curricula and training programmes.

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15 In this context, ‘interventions’ refers to the broad range of procedures, therapies, support approaches, devices and pharmaceuticals used by health and disability support practitioners.

16 The National Health Committee (2005) identified sub-specialisation as a key driver in the introduction of new interventions in DHBs, noting that ‘clinical staff often expect they will be able to practice all procedures in which they have experience … As a result, some newly appointed clinicians have been introducing new interventions without prior scrutiny by the DHB.’

17 One example of this shift is the rise of self-management programmes for people with chronic conditions.
APPENDIX TWO: THE HEALTH WORKFORCE ADVISORY COMMITTEE’S STRATEGIC PRINCIPLES AND ITS STRATEGIC PRIORITIES

HWAC’s 2003 document *The New Zealand Health Workforce Future Directions: Recommendations to the Minister of Health* (subsequently referred to as *Future Directions*) set out specific strategic priorities for workforce development. That report’s recommendations were grouped under seven priority actions, and the report also identified eight of its recommendations as immediate priorities that needed to be implemented as soon as was practical. This appendix takes the Strategic Principles identified in this document and briefly demonstrates how they relate to the recommendations in *Future Directions*. All quotations are from HWAC (2003).

**Equity and Appropriateness**

‘All communities in New Zealand must be able to expect equitable outcomes from health and disability support services, have equitable access to services that are provided in the manner most appropriate to their needs, and be able to participate in the health and disability support workforce on an equitable basis.’

Three of the *Future Directions* key priority areas are direct expressions of the Equity and Appropriateness principle:

- Priority Action 4: To Progress Māori Health Workforce Development
- Priority Action 5: To Progress Pacific Health Workforce Development
- Priority Action 6: To Facilitate Evolution and Development of the Health and Support Workforce to Better Meet the needs of Disabled People

All three of these priorities are about ensuring that the health and disability support sector workforce is both capable of effectively addressing the disparities in health outcomes experienced by these groups of people. For Māori and Pacific peoples, HWAC’s recommendations focus on the second aspect of this principle – reducing barriers to the development of Māori and Pacific health and disability support workforces – while for people with disabilities, they focuses on ensuring that the sector is responsive to their needs.

**Strategic and Sustainable Supply**

‘Development of the health and disability support workforce must be strategic in nature, reflect identified priorities and issues for the population, and ensure that New Zealand possesses an appropriate, sustainable and affordable supply of health and disability support practitioners.’

It is reasonable to say that all the recommendations made priority areas identified in *Future Directions* are geared towards realising this principle. HWAC is, after all, a strategic body, and the overall goal to which the recommendations contribute is identified as:
‘To recruit, train, employ, deploy and retain a health and disability workforce appropriate to meet the diverse needs of all New Zealanders in the short, medium and long term.’

All of Future Directions’ recommendations are designed both to ensure that New Zealand’s health and support workforce both reflects the strategic needs and priorities of the country and the sector, and to achieve a supply of practitioners that can be sustained over time. A particularly clear example of this, however, is Priority Action One: ‘To address the health workforce implications of The Primary Health Care Strategy’. Priority Action One explicitly and clearly links the development of the workforce to wider government strategies. It recognises that implementing the strategy entails a significant change to existing approaches to primary care, and that the workforce needs to be appropriately skilled to meet these challenges.

Healthy Workplaces

‘The health and disability support sector must be an attractive and healthy environment in which to work.’

Future Directions identifies ‘…the development of healthy workplace environments’ as one of its seven priority actions, and made the development of a set of national best practice guidelines for promoting such work one of its key recommendations requiring early implementation. HWAC has undertaken this task, and these guidelines are near completion and release.

Collaborative Practice

‘The health and disability support workforce must be encouraged and supported to work in an integrated, interdisciplinary and intersectoral fashion.’

Collaborative Practice is one of the key concepts underlying the recommendations in Future Directions. In particular, HWAC’s identification of workforce implications of The Primary Health Strategy as a Priority Action area necessarily entails a strong focus on determining how to best promote integrated, co-ordinated and intersectoral practice. For example, recommendation 1.1.2 – one of HWAC’s priorities for early implementation – is that the Ministry of Health ‘promotes and appropriately resources collaborative workforce practice within the health and disability sector’, and recommendation 1.2.6 is that District Health Boards ‘actively promote the use of public health, allied health and community health workers to deliver early intervention strategies in PHOs’.

Education

‘The health and disability support workforce must have access to appropriate and relevant education and ongoing training.’

Many of the recommendations in Future Directions explicitly deal with the principle of Education. ‘Facilitat(ing) the evolution and further development of
health workforce action’ is identified as a distinct Priority Action, and specific recommendations under this heading include that ‘collaborative planning, information sharing and teaching between the health sector and tertiary education providers is strengthened’, ‘health workforce education is responsive to changes in required skills for the diverse range of health practitioners’, ‘the teaching capability of staff, both academic and clinical, is supported and strengthened’, and ‘clinical and community placements are better co-ordinated and aligned to The New Zealand Health Strategy and The New Zealand Disability Strategy’.

In addition, both text and recommendations under other priority actions explicitly reference a need to identify the workforce’s skill and education requirements, develop appropriate education and training systems, support recognise prior learning, and build relationships between the two sectors. Examples of specific recommendations include that:

1.2.4 [DHBs] strengthen working links with local and regional education and training providers to ensure health workforce education is aligned with health service delivery.
1.3.0 The Tertiary Education Commission (TEC) consults with HWAC and the Ministry of Health about emerging models of health practice and utilisation of health practitioners.
4.3.0 The Ministry of Health collaborates with HWAC, the specialist advisory group, the TEC and health education providers to undertake a review of how current foundation, tertiary education and other clinical training programmes contribute to the development of the Māori health and disability workforce.
5.3.2 [The Ministry of Education, in collaboration with the Ministry of Health, ensures] the philosophies underpinning teaching and assessment methods are responsive to the learning needs of Pacific people.
6.1.1 [The Ministry of Health, in partnership] develop a programme of activities to enhance health practitioners’ knowledge of, and responsiveness to, disability issues.

**Stakeholder Involvement**

‘Effective health and disability support workforce development must be a collaborative process and involve a genuine commitment to participation and cooperation between all stakeholders, including consumers.’

The need to ensure the input and involvement of stakeholders, as a fundamental principle of public sector decision-making, is regularly referenced throughout Future Directions. Much of the discussion of the importance of this is in the ‘scene-setting’ material at the front of the document – and set down as a key principle in the discussion document that informed the final report – but many recommendations for particular organisations and institutions recommend that they undertake certain initiatives in consultation, collaboration or partnership with specific stakeholders. In addition, recommendation 1.2.2, ‘[that DHBs] strengthen consultation processes with
local employer and employee stakeholders…’, explicitly refers to the need to improve existing consultation processes – in this case, with specific regard to The Primary Health Care Strategy.

**Information and Monitoring Principle**

‘Effective health and disability support workforce development requires capturing relevant information, the capacity to use this information, and effective monitoring and evaluation tools.’

The Information and Monitoring principle is most clearly apparent in Priority Action Seven: ‘To facilitate the enhancement of health workforce research and evaluation capability’. The nine recommendations and sub-recommendations under this heading include those around supporting research on the health and disability support workforce, promoting information-sharing of practice evaluations, and improving the alignment between the academic research and health practice areas.
APPENDIX THREE: RELEVANT OVERARCHING PRINCIPLES

All the Health Workforce Advisory Committee’s work is underpinned by *The New Zealand Health Strategy* and *The New Zealand Disability Strategy*. The Strategic Principles in this document are thus founded on the overarching principles each of those strategies sets out for their respective sectors. In addition, the Committee has referred to the principles in the Australian Health Ministers’ Conference’s *National Health Workforce Strategic Framework*. This appendix sets out the principles in each of these documents.

**The New Zealand Health Strategy: Fundamental Principles**
(Minister of Health 2000)

**Acknowledging the special relationship between Māori and the Crown under the Treaty of Waitangi.**

This principle recognises that the Treaty of Waitangi is New Zealand’s founding document and the government is committed to fulfilling its obligations as a Treaty partner. This special relationship is ongoing and is based on the underlying premise that Māori should continue to live in Aotearoa as Māori. The nature of this relationship has been confirmed through interpretations of the Treaty of Waitangi, which stem from decisions of the Waitangi Tribunal, the Court of Appeal and the Privy Council.

Central to the Treaty relationship and implementation of Treaty principles is a common understanding that Māori will have an important role in implementing health strategies for Māori and that the Crown and Māori will relate to each other in good faith with mutual respect, co-operation and trust.

Māori should be able to define and provide for their own priorities for health and be encouraged to develop the capacity for delivery of services to their communities. This needs to be balanced by the Crown’s duty to govern on behalf of the total population.

To date, the relationship between Māori and the Crown in the health and disability sector has been based on three key principles:

- Participation at all levels
- Partnership in service delivery
- Protection and improvement of Māori health status.

Not only is it important to improve Māori health status, but other goals based on concepts of equity, partnership, and economic and cultural security must be achieved.

**Good health and wellbeing for all New Zealanders throughout their lives.**

This principle reflects the sector’s clear focus on good health and wellbeing. This applies at both the individual level (for example, with treatment services)
and the community level (for example, with health promotion services), and that continued throughout people’s lives. The Government recognises that good health and wellbeing rely on a range of factors, many of which are outside the health sector. The sector must, therefore, seek to move towards more intersectoral ways of working to ensure these linkages can be made, both centrally and locally.

An Improvement in the health status of those currently disadvantaged. This principle identifies the opportunity for health improvements within the population. The benefits of health improvements are not shared equally by all sectors of society. An increase in effort is needed to address the low health status of groups with low socio-economic status, including Māori and Pacific peoples, and people with serious mental illness.

Collaborative health promotion and disease and injury prevention by all sectors.

This principle reflects the Government’s desire to have a health system that promotes good health and ‘wellness’ as well as treating illness. Many of the illnesses affecting the New Zealand population are potentially preventable, and we need to do better at addressing all the determinants of health.

Timely and equitable access for all New Zealanders to a comprehensive range of health and disability services, regardless of ability to pay.

This principles reflects the fact that fairness is a fundamental value for most New Zealanders, and the health sector must ensure that New Zealanders with similar health outcomes are able to achieve similar outcomes.

A high-performing system in which people have confidence.

This principle reflects the fact that the health sector must continue to perform to the highest standards and reflect the needs of the people of New Zealand within available resources. The quality of health services needs to be continually monitored and improved. Services must be co-ordinated, and providers must collaborate to ensure institutional boundaries do not compromise quality of care. Inefficiency means there are fewer health services available for each dollar spent.

Active involvement of consumers and communities at all levels.

This principle identifies the need to have consumers and communities involved in decisions that affect them. This process should also ensure services at all levels of the health sector fully reflect the needs of individuals and communities.
The New Zealand Disability Strategy's Vision of a Non-disabling Society
(Associate Minister of Health and Minister for Disability Issues, 2002)

The New Zealand Disability Strategy sets out a vision of an inclusive society in which people with impairments are able to say that they live in:

'A society that highly values our lives and continually enhances our full participation.'

This will happen in a country where:

- Disabled people have a meaningful partnership with Government, communities and support agencies, based on respect and equality.
- We have moved forward from exclusion, tolerance and accommodation of disabled people to a fully inclusive and mutually supportive society.
- Disabled people are integrated into community life on their own terms. This means that equal opportunities are assured by individual choices are available and respected.
- The abilities of disabled people are valued and not questioned
- Interdependence is recognised and valued, especially the important relationships between disabled people and their families, friends, whānau and other people who provide support.
- Human rights are protected as a fundamental cornerstone of government policy and practice.
- The diversity of disabled people, including their cultural backgrounds, is recognised, and there is flexibility to support their differing aspirations and goals.
- Disabled people are treated equitably, regardless of gender, age, cultural background, type of impairment or when and how the impairment was acquired.
- Community-based services ensure that disabled people are supported to live in their own communities, and institutionalisation is eliminated.
- The idea that society imposes many of the disabling barriers faced by people with impairments is widely understood and, therefore, legislation, policy and other activities enhance rather than disable the lives of people with impairments.
- The principles of the Treaty of Waitangi are recognised.

The Australian National Health Workforce Strategic Framework: Guiding Principles
(AHMC 2004)

1. Australia should focus on achieving, at a minimum, national self-sufficiency in health workforce supply, whilst acknowledging it is part of a global market.

2. Distribution of the health workforce should optimise equitable access to health care for all Australian, and recognise the specific requirements of people and communities with greatest need.
3. All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration.

4. Cohesive action is required among the health, education, vocational training and regulatory sectors to promote an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes.

5. To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.

6. Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence.

7. Australian health workforce policy development and planning will be most effective when undertaken collaboratively involving all stakeholders. It is recognised that this will require:
   - cohesion among stakeholders including governments, consumers, carers, public and private service providers, professional organisations, and the education, training, regulatory, industrial and research sectors;
   - stakeholder commitment to the vision, principles and strategies outlined in this framework;
   - a nationally consistent approach;
   - best use of resources to respond to the strategies proposed in this framework; and
   - a monitoring, evaluation and reporting process.
APPENDIX FOUR: THE HEALTH WORKFORCE ADVISORY COMMITTEE

The Health Workforce Advisory Committee (HWAC) is established under Section 12 of the New Zealand Public Health and Disability Act 2000. The role of the Committee is to advise the Minister of Health on health workforce issues that the Minister specifies by notice to the Committee.

The Committee's key tasks, in line with the requirements of Section 12 of the New Zealand Public Health and Disability Act 2000, are to:

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

Other tasks may be undertaken as agreed between the Minister and the Committee.

In developing its advice, the Committee may consider:

- What is currently known about workforce, in particular: a stocktake or analysis of previous reviews and reports, and patterns of shortage, excess or other imbalance in existing workforce capacity, geographically or in specific service areas.
- The type of workforce required for the future, taking account of service, educational, societal and technological trends and public expectations.
- The changes necessary to move from the present to a recommended health workforce capacity, utilising current system strengths that can be built on and identifying barriers and possible resolutions.
- Co-ordinated strategies or co-operative approaches to achieve necessary changes in education, training, recruitment and retention, and occupational regulation.
- Any other issues impacting on workforce (eg, inter-agency or intersectoral issues, funding, training support).
- Such other matters as the Minister specifies by notice to the Committee.

Membership of the Health Workforce Advisory Committee is broad-based, with members bringing extensive sector networks and other linkages and perspectives to Committee deliberations. The Committee is supported by a Secretariat based in the Ministry of Health.