The New Zealand Health Workforce

Framing Future Directions

Analysis of Submissions
and
Draft Recommendations
to the Minister of Health
for Health Workforce Development

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EXECUTIVE SUMMARY

Introduction

The New Zealand Health Workforce *Framing Future Directions* discussion document was released in October 2002 and distributed to over 3000 key stakeholders and interested parties. The document invited organisations and individuals to participate in planning for development of the New Zealand health workforce and comment on six priority areas for development.

These priority areas relate to the chapters and questions throughout the discussion document:

- Addressing the workforce implications of the Primary Health Care Strategy
- Promoting a healthy hospital environment
- Educating a responsive health workforce
- Building Mäori health workforce capacity
- Building Pacific health workforce capacity
- Building the health and support workforce capacity for people who experience disability.

Submission analysis

The Health Workforce Advisory Committee received 111 submissions on the document (see Appendix One) during January and February 2003, from professional associations and colleges, regulatory bodies, District Health Boards, individuals, non-government organisations and Government agencies. The committee also held eight meetings, hui and fono in November and December 2002 (see Appendix Two) in order to acquire information for the development of a New Zealand health workforce development strategy.

Key themes

The following themes reflect the feedback received from the respondents on the six priority areas.

Workforce implications for the Primary Health Care Strategy

There is very strong support from the stakeholders for the proposals in this chapter. The areas that are most strongly supported are funding for staff development, fostering teamwork within primary care, the development of primary health care competencies, and the implementation of action research and information sharing. Many of these stakeholders made comments or suggestions about the Primary Health Care Strategy. Their key points are summarised below:

- There should be a role for allied health practitioners within Primary Health Organisations (PHOs) to promote health prevention activities and screening programmes within the community.
- Insightful governance by District Health Boards is essential, to ensure that they and their clinical leaders and managers are knowledgeable about primary health care strategies.
- Fostering teamwork within primary health care, such as leadership partnerships and leadership models, could encourage clear and open co-operation between clinicians and managers.
- National and regional evaluations of any current and new skill mix models in the primary health care setting are required.
- Financial, environmental and personal incentives are needed to attract health practitioners to isolated or disadvantaged areas, e.g. higher salaries, locum relief and administration support.
- An agreed set of primary health care competencies should be developed for existing primary health practitioners, health practitioners wishing to move into primary health care and students training in primary health care.
- Action research projects and the development of forums to share information across the primary health care sector need to be implemented.
- Funding for the establishment of: staff development, so that organisations can purchase continuing education opportunities, initiatives such as nurse-run clinics, the utilisation of research and development, the development of action research, and for the implementation of the Primary Health Care Strategy.

Promoting a healthy hospital environment

There is broad agreement from the stakeholders for the proposals in this chapter. The areas where there is strong agreement are trustworthy consultation with staff, supporting staff in the medico-legal environment, the implementation of sound management policies, the collection of data, and work-based training programmes.

Many stakeholders made comments or suggestions about promoting a healthy hospital environment, and their key points are that there should be:

- implementation of trustworthy consultation processes that could facilitate staff participation and provide feedback opportunities within organisations
- utilisation of clear policies, guidelines, no blame reporting systems and education that would support staff in the medico-legal environment
- implementation of sound management methodology that is congruent with organisational values
- collection of information at organisational, regional and national levels to give an accurate and comprehensive view of the current health care workforce

- effective education and training programmes that would ensure the professional and personal development of both New Zealand- and overseas-trained practitioners
- implementation of research and data collection that could assist in the evaluation of staff morale within organisations, e.g. culture surveys and staff turnover statistics.

Educating a responsive health workforce

This chapter attracted significant interest and divergent views from the stakeholders on key issues. The areas that are particularly supported are ensuring collaboration between health and education, the development of scopes of practice, and the development of generic competencies. Many of these stakeholders made comments or suggestions about educating a responsive health workforce, and their key points are summarised below:

- Advancement of intersectoral collaboration between all the key players in health and education, such as the District Health Boards, tertiary institutions and professional bodies, could ensure effective workforce development.
- The defining and development of scopes of practice could enable employers with different needs to have greater clarity and flexibility. However, the impact of expanding scopes of practice on public safety should be evaluated.
- The development of generic competencies could assist in the reduction of the duplication of training programmes, support the rural workforce in their delivery of health care, and become an integral component of practice for all practitioners within their specific disciplines.
- The establishment of collaborative research and development projects could foster close relationships and mutual governance of education programmes. However, there is a need to resource research time for General Practitioners.
- The development of accessible educational programmes should attract increasing numbers of Mäori, Pacific Island and rural students, as distant education allows participants to work within their own communities.

Building Mäori health workforce capacity

There is general agreement and enthusiasm from the stakeholders for the implementation of the proposals in this chapter. The areas where there is strong agreement are the establishment of a national Mäori health workforce organisation, the development of career pathways, and the development of a multi-level marketing strategy to recruit Mäori. Many of these stakeholders made comments or suggestions about building Mäori health workforce capacity, and their key points are summarised below:

- It is essential that there be consideration of the factors that are crucial to the development of the Mäori workforce, e.g. the contextual infrastructure in which Mäori operate (housing, education, for example).
- The establishment of a national Mäori health workforce organisation led by Mäori could guide the implementation of a national vision and strategy for health workforce development.

- The development of career pathways for Mäori is needed, in order to recruit and retain a higher proportion of Mäori staff. This development should include the utilisation of Mäori preferred-employer criteria and the recognition of Mäori specific skills.
- Mäori led research, such as the establishment of a Mäori Health Workforce Research Unit, could assist in the enhancement of Mäori workforce capacity.
- The Ministry of Health should ensure the collection of consistent Mäori health workforce data by District Health Boards.
- Allied health should have the highest priority for Mäori health workforce development given that there are fewer Mäori in allied health compared to other practitioner groups.
- A multi-level Mäori health education and health workforce marketing strategy should be developed. This strategy could include the use of role models and targeting children at an early age.

Building Pacific health workforce capacity

There is broad agreement from the stakeholders for the proposals in this chapter. However, the feedback is lower than for other chapters, because of the low participation in fono and the small number of submissions made on building Pacific health workforce capacity. The respondents who commented on this chapter tended to be professional associations/colleges/bodies and District Health Boards.

The areas where there is broad agreement are the development of career pathways for Pacific peoples and the use of responsive teaching methods in the education sector. Many of these stakeholders made comments or suggestions about building Pacific health workforce capacity, and their key points are summarised below:

- Consideration is needed of the factors that are crucial to the development of the Pacific workforce, e.g. the lack of acknowledgement that the Pacific Island community is made up of a number of smaller communities.
- Career pathways for Pacific people should be developed, such as bridging programmes for Pacific Island people coming to New Zealand, as there is currently a lack of pathways into the New Zealand workforce. This development should include working with employers to establish Pacific policies and to build capacity.
- Responsive teaching methods, such as culturally specific teaching and assessment methods are needed to ensure active participation of Pacific peoples in education.
- Investment in the Pacific provider environment will develop the clinical and management capacity of the Pacific workforce because it will provide opportunities for Pacific peoples to gain skills and expertise.
- Workplace strategies should be established to assist in the recruitment and retention of the Pacific health workforce, e.g. cultural support networks in the workplace.
- A national Pacific health workforce development group should be established to co-ordinate Pacific development activities.

Building the health and support workforce capacity for people experiencing disability

There is general agreement from the stakeholders for the implementation of the proposals in this chapter. The areas where there is strong agreement are the use of the disability health and support framework, intersectoral responsibility for disability education for practitioners, and training of the support workforce and of the needs assessment and service co-ordinators. Many of these stakeholders made comments or suggestions about building the health and support workforce capacity for people experiencing disability, and their key points are summarised below:

- Barriers should be removed and participation in the health and support workforce promoted, for people experiencing disability.
- There is general support for the disability health and support framework, but there is a need for clarification, as it is not fully understood by a number of the stakeholders.
- Development of intersectoral responsibility between relevant parties should be fostered, such as central government, the education sector and District Health Boards for the investment in disability education for all health practitioners.
- A local population needs assessment plan undertaken at a District Health Board level should be implemented, and a national stocktake undertaken of the workforce that could be fed into national workforce planning.
- The development and delivery of training and national qualifications for the support workforce, which would benefit the worker and the person experiencing disability.
- The development of a needs assessment and service co-ordinator national training programme to ensure assessment and service meet a high standard.

Overall comments

There is strong support for the *Framing Future Directions* discussion document and the work of the Health Workforce Advisory Committee (HWAC). The stakeholders welcome the publication of the document and consider it a sound platform on which to base further discussion regarding the development of a New Zealand health workforce development strategy. The stakeholders also commend the committee for their commitment, and focus on long-term remedies. However, the stakeholders noted a number of omissions. The key omissions are as follows:

- The lack of concentration on short-term issues.
- The need for a stronger focus on medical workforce development
- The lack of a public health workforce development plan for the recruitment, training and retention of public health workers.
- The urgent need to address nursing shortages, as there is a serious deficit of nurses in speciality areas.
- The lack of an alternative/complementary medicine perspective within the document.

INTRODUCTION

The *'Framing Future Directions'* discussion document was released on 9 October 2002. The document was distributed to approximately 3300 key stakeholders and interested parties. The contact list for this sector-wide consultation was generated from a database of key stakeholders comprising District Health Boards, health or disability providers, education providers, professional bodies and associations, Pacific providers, public health managers, independent practitioner associations, government agencies, the disability sector, unions, advocacy groups and interested parties. Approximately 500 documents were also distributed at the eight consultation meetings, hui and fono held during November and December 2002.

The document was also posted on the Health Workforce Advisory Committee website, whereby respondents could complete an online submission form or download a submission form and email their comments to the committee.

The document asked organisations and individuals to have their say on the development of the New Zealand health workforce. There were six priority areas for comment, which refer to the chapters and sections throughout the discussion document. These priority areas are:

- Addressing the Workforce Implications of the Primary Health Care Strategy
- Promoting a Healthy Hospital Environment
- Educating a Responsive Health Workforce
- Building Mäori Health Workforce Capacity
- Building Pacific Health Workforce Capacity
- Building the Health and Support Workforce Capacity for People who Experience Disability.

The document also included an area for any other comments the respondent wished to make. The respondents were also asked to consider and comment on the suggested next steps proposed by the Health Workforce Advisory Committee.

Submission analysis

Number of submissions

The Health Workforce Advisory Committee received 111 submissions during January and February 2003 commenting on the *Framing Future Directions* discussion document' (see Appendix One). Some of the submissions from particular sectors made identical or similar comments, such as Nurse Education in the Tertiary Sector and Whitireia Community Polytechnic, School of Nursing and Health Studies; the Dietitians Board and the University of Otago, Dietetic Training; and Greenlane Hospital, Home and Older Peoples Health and New Zealand Dietetic Association. There are also similar overall comments between the Clinical Leaders Association of New Zealand and Waitemata District Health Board; and the Dental Council of New Zealand, the Medical Council of New Zealand and the Dental and Medical Councils of New Zealand (joint submission).

Table 1 shows that over a third (38%)[1] of the submissions were received from a professional association, college or body, 17% from District Health Boards, 10% from individuals, 31% from non-government organisations and 4% from government agencies including the Ministries of Health and Education.

Table 1: Respondents by type

Type of respondent	Number	Percentage
Professional associations/colleges/regulation bodies	43	38%
District Health Board employees or organisation	19	17%
Service user/carer/practitioner	11	10%
Disability provider	11	10%
Health provider	8	7%
Education provider/research organisation	8	7%
Iwi provider	4	4%
Government agency	4	4%
Social service provider	3	3%

Methodology

A qualitative approach was used to analyse the submissions into key themes within a pre-developed database. The format of the database was according to the *Framing Future Directions* discussion document chapters and sections. The sections were broken down into key themes in order to cover various comments that the respondents made on particular questions that were asked in the discussion document.

[1] Please note: The respondents may have made comments on more that one chapter and therefore the percentages are based on the total number of responses out of 111. Percentages have been rounded to the nearest whole number.

The respondents' comments within the sections and themes were compared with each other and with other comments in the overall section. These comments were then categorised into the key themes on which this document is based. Various key stakeholders were identified if they had made strong comment on a particular subsection or theme, e.g. District Health Boards, professional associations/bodies, the nursing sector, iwi organisations and the disability sector.

Consultations

Eight consultation meetings, hui and fono (see Appendix Two) were held during November and December 2002. Participants at these consultations were asked for their feedback on the chapters within the *Framing Future Directions* discussion document. They were also asked:

- What did they think the most immediate action should be?
- What were the key issues?
- Where were there gaps in the document?
- How should the situation be different in 10 years' time?

The participants at the consultation meetings, hui and fono discussed the questions generally as well as in smaller discussion groups that focused on the chapter topics. The information gathered identified some implications for the development of the New Zealand health workforce strategy.

Most of the information gathered from the participants at the consultations reflects the comments in the written submissions. However, some ideas and information differed, particularly relating to the feedback on building Pacific health workforce capacity.

ADDRESSING THE WORKFORCE IMPLICATIONS OF THE PRIMARY HEALTH CARE STRATEGY

Introduction

Eighty-seven organisations and individuals (79% of submissions) made comments on Chapter One of the *Framing Future Directions* discussion document. The key themes identified include:

- the role of allied health practitioners within the primary health care service
- insightful governance by the District Health Boards
- fostering of teamwork in primary health care
- evaluation of any current and new models for effective skill mixes
- incentives to attract health practitioners to isolated or disadvantaged areas
- the establishment of primary health care competencies for all practitioners
- the implementation of action research and information sharing
- funding for staff development, initiatives such as nurse-run clinics, research and development of skill mixes, action research, and implementation of the Primary Health Care Strategy.

Service delivery context

Current concerns

The New Zealand Medical Association submitted that there is a 'serious lack of understanding of the depth of feeling general practitioners have about the uncertainty of the future of general practice, and the safety and well being of the patients' (New Zealand Medical Association). The Association continued that:

> 'General practice is under great stress. Many GPs, uncertain of their future role are feeling under-valued and are leaving, and recruiting their replacements is extremely difficult. The uncertainty of the current reforms is adding to the pressure' (New Zealand Medical Association).

A similar view was expressed by the Royal New Zealand College of General Practitioners who commented that 'it is well known there is a declining interest in general practice as a career. The College is experiencing an increasing loss of medical graduates and declining interest in training for general practice' (Royal New Zealand College of General Practitioners). It is thought that there is a 'lack of understanding of what it is GPs actually do' and that they make use of skills which are 'often unknown or poorly appreciated outside of primary care … [but which are] part of the art of general practice and come with experience [rather] than education' (New Zealand Medical Association).

Nurses feel that 'there are too few opportunities for nurses in primary care and the nursing workforce is not used to its full potential. The establishment of some nurse practitioner positions in primary health care would be an important signal that nurses do have career advancement opportunities in primary health care' (New Zealand Nurses Organisation).

This theme was also picked up by the education sector, which commented that 'there are no satisfactory education pathways for primary health care nurses and, in particular, there are no opportunities for practice nurses to obtain education for the role other than comprehensive education as a nurse practitioner, requiring completion of a Masters degree' (University of Auckland, Faculty of Medical and Health Sciences).

Role of allied health practitioners

Many respondents commented on the role of allied health practitioners including physiotherapists, clinical psychologists, social workers, dietitians, and dentists in providing early intervention within the primary health care service, particularly within Primary Health Organisations.

> 'Allied health practitioners can play a key role in health prevention and promotion of activities within the community ... They would be an integral part of multidisciplinary team care delivery from PHOs' (MidCentral DHB).

It was also suggested that there be a 'structural mandate that allied health professionals should be part of the primary health care service' and that in order that a 'medical model of primary health' is not developed allied health be 'central to the model' (Canterbury DHB – Mental Health Services). However, it was noted that some practitioners, such as midwives, have already 'developed their own distinct support and infrastructure [and this is] not necessarily best placed within the PHO model' (New Zealand College of Midwives).

The role of allied health practitioners in early intervention in primary health care was also commented on. In particular, it was suggested that allied health practitioners 'should have an integral role within a collaborative team approach to promote wellness in communities for enrolled populations at risk, and people who present at PHOs' (Auckland University of Technology). These practitioners could include professional groups, such as pharmacists who could be 'part of PHOs and help with patient care through their [diabetes, blood pressure] screening programmes, medication reviews and education on the use of medicines' (Linda Caddick).

Planning – workforce development strategies

Many respondents thought it 'essential' that all District Health Boards and Primary Health Organisations 'have a comprehensive workforce development plan/strategy' (Taranaki Health – Health Promotion Unit). Such a staffing plan could outline a Board's requirements for staff for the short-, medium- and long-term' (Association of Salaried Medical Specialists). It was also suggested that the strategies should include 'models for future leadership development and succession planning' (Bay of Plenty DHB – Nursing) and 'enable appropriate education, mentoring etc to those with leadership potential' (MidCentral DHB).

Some respondents thought that the strategies should be 'specific to their own context' (Family Planning Association), whereas others commented that they should be 'guided by an overall national strategy to ensure consistency and congruence' (New Zealand Nurses Organisation). Provided DHBs 'are required to have a workforce development strategy and are adequately funded to implement it … there should be no need for a more prescriptive approach' (New Zealand Federation of Vocational and Support Services).

It was noted that 'while there are local or regional aspects to workforce issues, central planning is vital so that funds are not fragmented' (Canterbury DHB). It was suggested that planning also include:

- research and evaluation that is fed into the plans (Canterbury DHB)
- alignment with other health strategies (Auckland DHB – Nursing)
- transparent processes (New Zealand Dietetic Association)
- ownership of the strategy (Choice Health, Wairarapa DHB).

Role of public health

Some of the respondents commented that public health could be incorporated into Primary Health Care organisations through:

> 'a more deliberate and concerted effort … to build a systemic infrastructure that is properly supported at all levels, national, regional, and local, to deliver effective public health action into the next decade … The public health partnership model in Australia could be a worthwhile model to investigate' (Auckland DHB).

However, 'effective implementation of the Primary Health Care Strategy [would] require additional public health workers, and additional public health skills amongst the primary health care workforce' (Public Health Association of New Zealand).

Funding for staff development

There was strong support for Primary Health Care organisations to receive adequate funding so they can provide or purchase continuing education and upskilling opportunities for all primary health workers, and not just doctors and nurses' (Canterbury DHB). The 'development of the nurse practitioner role would require commitment of funding to support nurses to attain the necessary educational qualifications' (Lakes DHB).

It was suggested that there could be 'investment in funding development of skills and knowledge in tackling inequalities and determinants in health, such as community development, advocacy, public policy and planning' (Health Promotion Forum of New Zealand).

Interface between PHOs and DHBs

Some respondents commented that 'bringing clinical leaders from PHOs together with planning and funding staff of DHBs in order to build a common understanding and culture' (Clinical Leaders Association of New Zealand) could be an important strategy. Greater liaison between various sectors could result in a team approach with all mainstream and alternative health care providers involved (i.e. Mäori, Pacific, Chinese medicine, GPs, Plunket, naturopaths etc) (Auckland DHB) '... [and] will help to promote a collaborative environment and erase the competitive element that has previously characterised the relationships between these practitioners' (Family Planning Association).

The role of the District Health Boards

Insightful governance

Insightful governance was seen as an important issue for District Health Boards. They also needed to 'identify and nurture leadership and leadership competencies'. District Health Boards could 'ensure that their members, clinical leaders, and managers are knowledgeable about primary health care' through the participation in leadership training (Faculty of Medical and Health Services, University of Auckland). Leadership training could be 'similar to that offered in other sectors 'such as the *Kellogg* programme run through Lincoln University' (New Zealand Federation of Vocational and Support Services). However, 'DHBNZ has established the Leadership and Management Programme (LAMP)' but does not recognise the formation of a 'model of clinical leadership' based on programmes of management training whereby clinicians become managers (Clinical Leaders Association of New Zealand).

Other respondents suggested that it was important for District Health Boards 'to cultivate and use primary health care expertise' (Royal New Zealand College of General Practitioners) along the lines of Auckland DHB which 'recently created a new role of Director of Allied Health' (Auckland DHB) and the "Work Structuring" methodology being applied at Waitakere Hospital which is expected 'to deliver substantial benefits (Waitemata DHB).

Intersectoral collaboration

Intersectoral collaboration is an effective way of creating a primary health care partnership. Respondents suggested that the 'DHBs' strategic plans should consider a strengthened community-type approach that forms partnerships and relationships including regular hui with Mäori providers' (Hawkes Bay DHB). It was suggested that a partnership between DHBs, 'consumers and their families, the health workforce and the community' – 'The Waitakere Way' matrix – is an effective strategy (Waitemata DHB).

Promotion of the Primary Health Care Strategy

Some respondents suggested that District Health Boards should promote the Primary Health Care Strategy as they have a 'responsibility to ensure consumers and all providers have an understanding of the Strategy and of the key goals of the DHB' (Nurse Executives of New Zealand). It was suggested that promotion of the Primary Health Care Strategy would be best provided on a national basis with education delivered locally by a national team (Pharmaceutical Society of New Zealand).

Redesigning primary health care services

Teamwork

There was strong support from most stakeholders for the fostering of teamwork within primary health care. The development team at Waitakere Hospital has a 'leadership partnership between the General Manager, the Clinical Leader and the Nurse Leader' (Waitemata DHB). But it was also noted that 'there are two levels of training through which teamwork could be fostered: training teams together … [and] … training teams to work together' (Royal New Zealand College of General Practitioners).

Some respondents suggested leadership models to encourage co-operative relationships between clinicians and managers (New Zealand Nurses Organisation).

'Implementing quality philosophy in regard to teams membership and functioning. Mutual respect and recognition of contribution to the advancement of health are fundamental building blocks of teamwork. Role modelling in the sector of inclusivity of key health stakeholders at every level in the sector will promote interdisciplinary teamwork and signal expectations' (Nurse Executives of New Zealand).

Co-operation could be 'achieved through the development of clear guidelines' (Northland DHB – Te Poutokomanawa Mäori Directorate) and 'clear and open lines of communication when determining objectives' (Choice Health, Wairarapa DHB). Fostering understanding between professions could be achieved through 'contextual understanding and clarity around roles and tasks of all team members' (Royal New Zealand College of General Practitioners).

Teams 'need time to grow, and under the current working conditions with staff shortages and high staff turnover, this is difficult to achieve' (New Zealand Institute of Medical Radiation Technology). To address this:

> 'All cost/price disincentives to fully utilising the whole primary health care team must be removed. Some initial "ring-fencing" of funding for initiatives such as nurse-run clinics or community health worker programmes may assist' (Lakes DHB).

One respondent noted that under the new primary health care models 'it is likely that the levels of responsibility currently held by many health practitioners in primary care will increase in the future' (University of Auckland, Faculty of Medical and Health Sciences).

> In order for 'multidisciplinary teams to be effective, health professionals must be accountable for their own personal practice and must recognise and respect the contributions of other team members' (Royal New Zealand College of General Practitioners).

Person-centred care

The use of person-centred care could foster multi-disciplinary teamwork and facilitate co-operation between generic and specialist care. A 'focus on quality, and ensuring measurement of patient outcomes through robust clinical data systems, are known to focus activity, increase shared understanding and enhance relationships' (Nurse Executives of New Zealand). By focusing all primary health care on patients, 'managers and clinicians will be working towards the same objective' (Pharmaceutical Society of New Zealand).

Further, '[scopes of practice] must avoid disputes about overlap by focusing on improved patient outcomes rather than professional regulation. Better collaboration between nurses and doctors can improve patient care and staff satisfaction, as well as lower costs' (Royal New Zealand College of General Practitioners).

It was suggested that 'rather than individualised scopes of practice, the professions instead believe that we should focus on broad scopes of practice for each profession, thus retaining flexibility in the workforce' (Association of Salaried Medical Specialists).

Community health workers

A number of respondents stated that the responsibility for recruitment and training of community heath workers lay with the employer. Without support and training from hospitals for relatively inexperienced community-based sole practitioners, 'some community positions may remain vacant for long periods' (Auckland District Health Board).

> 'Health providers are in the best position to accept the responsibility for the recruitment and providing a pathway for training opportunities … This process has been demonstrated through the Mäori Provider Development Scheme' (Tuwharetoa Health Services).

It was thought that 'the best training is delivered by qualified trainers who will educate according to a standard curriculum' (The Institute of Rural Health).

Effective skill mix

Evaluation of skill mix models

Many respondents suggested that there should be a national and regional evaluation of any current and new models for effective skill mixes. In particular, it was suggested that 'the Ministry of Health should commission an evaluation of successful models of workforce innovation in the primary health care setting' (University of Auckland, Faculty of Medical and Health Services) and that this evaluation could be outsourced to universities (Royal New Zealand College of General Practitioners).

Funding should be 'made available for research and development in primary care including evaluation of workforce innovations' (Clinical Leaders Association of New Zealand). It was also suggested that there should be a 'provision of toolkits' to 'assist with establishing measurement criteria' (Nurse Executives of New Zealand).

It was stated that 'the government needs to ensure that the service that the community receives is a safe and efficient service' (Royal New Zealand Plunket Society). To ensure this, the skill mix should include 'support workers, community workers, Mäori and Pacific workers' (Janet Peters).

Guidelines

Some respondents suggested that there should be central guidelines and monitoring for skill mixes. 'Central government needs to establish outcome targets and effective monitoring' of the developing workforce (Family Planning Association), and that its role and that of 'DHBs needs to be facilitatory and supportive rather than controlling (Clinical Leaders Association of New Zealand). It was also suggested that there could be national 'core requirements' with regional differences (New Zealand College of Practice Nurses).

Maldistribution and shortages of health practitioners

Incentives – financial, environmental and personal

Many of the stakeholders commented that financial, environmental and personal incentives were needed to attract practitioners to isolated or disadvantaged areas. Incentives were 'strongly preferable to bonds' (New Zealand Medical Students Association), although it was also suggested that there could be a 'waiver of student debt in exchange for bonding/service in high need areas' (Auckland University of Technology).

It was suggested that rural practitioners should have 'a salary marginally higher than their urban colleagues' (The Institute of Rural Health) and that graduates originating from areas of shortage should be encouraged to return after completing their studies, to address problems of recruitment and retention in the rural workforce (Auckland District Health Board).

However, others suggested that practitioners needed 'regular locum relief' (New Zealand College of Practice Nurses) and 'limited period postings' (New Zealand Nurses Organisation). Some suggested that the provision of technology would enable continuing professional development through 'telemedicine and teleconferencing' (Medical Council of New Zealand) and others perceived that the recognition and support of partners as family/whänau units is important (Auckland DHB). It was commented that 'administration support is an important part of the practice infrastructure' (Royal New Zealand College of General Practitioners).

Shortages

Some respondents commented that it is important to retain New Zealand graduates because 'practitioners who are trained in New Zealand provide the best service for New Zealanders, and retention of the current workforce is more cost effective than importing overseas trained practitioners on a temporary basis' (Dental and Medical Councils of New Zealand). However, it was suggested that overseas doctors be placed as GPs 'within multidisciplinary groups in a population-based primary health care network' (New Zealand Overseas Doctors Association Inc).

Another respondent commented that it would be useful to look at the factors influencing retention such as career aspirations (Capital Coast DHB). Others suggested that 'marketing lifestyles', recruiting students from rural areas (Pharmaceutical Society of New Zealand) and mentoring (Auckland DHB) were useful recruitment strategies. It was also suggested that research could be used to evaluate staff retention in rural areas such as through exit interviews (Pharmaceutical Society of New Zealand), and that 'PHO developments may have a positive impact on the maldistribution' of the workforce (Lakes DHB – PHO Contracts). Some professional associations, such as dental therapists, sexual physicians and radiation technicians, commented that there is a need for strategies to address their particular workforce shortages.

One respondent stated that there was no shortage of GPs in New Zealand:

> 'The current maldistribution of GPs is closely linked to the financial barriers New Zealanders experience in accessing primary health care. This results in a surplus of GPs in areas where patients can pay the high co-payments, such as central Auckland. Conversely, there is a gross undersupply in disadvantaged populations such as Tairawhiti. Much fuller financial access to primary care, on a capitated basis allowing for needs, could do much to achieve the redistribution needed. There is no shortage of GPs in New Zealand, just a serious maldistribution' (Clinical Leaders Association of New Zealand).

Educating and training primary health care practitioners

Primary health care competencies

Most of the stakeholders commented that primary health care competencies should be established for all practitioners, including existing primary health care practitioners, health practitioners wishing to move into primary health care and students training in primary health care.

> 'All health practitioners should be educated at undergraduate level in the principles of primary health care. These principles should be included in all ongoing education for professionals who are experienced in secondary care settings wishing to transfer to primary health care settings, and [for] experienced health professionals who are entering our workforce for the first time in either setting' (New Zealand College of Midwives).

It was also stated that 'the sector needs to define what core competencies are required … It then becomes a matter of having those competencies included in the curriculum' (The Institute of Rural Health). The New Zealand Nurses Organisation supported the primary health care competencies identified in the document as the basis of an education/training strategy (New Zealand Nurses Organisation).

Education and training

Some respondents commented that there is a need to co-ordinate the provision of ongoing education. It was perceived that 'collaboration between universities, polytechnics and Mäori educational wananga would extend the scope of curricula available to health professionals' (Tuwharetoa Health Services). Others commented that students should be exposed to a range of environments, such as 'varied training programmes where the trainee has access to several different environments, including general practice and rural work' (Medical Council of New Zealand). It was also suggested that 'the development of a School of Rural Health would provide the opportunity to meet the needs specifically of rural communities' (Tuwharetoa Health Services).

Implementation

Action research

There was strong support from most of the stakeholders for action research provided it is adequately funded. However, there was no clear consensus of how action research could be implemented and it was suggested that 'this topic should be discussed at the summit' (Nurse Executives of New Zealand). Respondents suggested that action research should:

- focus 'on the wider primary health care workforce and not just medical professionals' (New Zealand Federation of Vocational and Support Services)

- 'reflect the needs of communities and have the end goal improving health outcomes and service delivery' (New Zealand College of Midwives)
- 'inform on primary health care workforce development' (Faculty of Medical and Health Services, University of Auckland) and
- 'be linked to currently funded PHO workforce projects, including rural workforce retention funding, primary care nursing innovations, and rural nursing innovations' (Canterbury DHB).

Information sharing

There was strong support from most of the stakeholders, particularly District Health Boards, for a national forum to share information. It was thought that 'national forums would play a significant part in the sharing of innovation and information across the country [and] raise the profile and awareness of the Primary Healthcare Sector' (Auckland DHB – Nursing). They would also provide an opportunity to 'hear of health gains, e.g. for Mäori [this] is essential' (Waikato District Health Board). However, 'the costs associated with national forums need to be kept to a minimum, particularly for NGO providers. NGO providers may require assistance in funding staff to attend' (Lakes DHB).

Implementation of the Primary Health Care Strategy

For the *Primary Health Care Strategy* to be effectively implemented and to achieve improvements in health, it was suggested that it would require:

> 'an increase in the public health workforce to meet the specialised demands of a population orientation to primary health care; most primary health care workers to learn new skills and knowledge about public health issues and strategies, and the development of the community health workers' workforce' (Auckland DHB).

In addition, effective implementation would also require 'careful co-ordination with the development of implementation plans, and a monitoring mechanism to measure [the] success of implementation…Clear guidelines and education frameworks with appropriate resources prior to the introduction of the new models would also be needed' (Lakes DHB). It was suggested that there should be an injection of funds into mental health and PHOs if the strategy is to be implemented effectively (Lakes DHB).

Consultation meetings

Most of the participants at the consultation meetings, hui and fono made comments about the workforce implications of the Primary Health Care Strategy that were similar to the comments made in the submissions. For example, comments made on:

- the intersectoral approach of allied health professionals
- planning of workforce strategies
- the role of public health
- intersectoral collaboration across the sectors

- promotion of the Primary Health Care Strategy
- teamwork
- financial and environmental incentives
- information sharing
- funding.

The participants also put forward a number of new ideas at the meetings. These include:

- communication of the value of the primary and community sector (Christchurch 27 November).
- where is the provision for other services, such as voluntary organisations (Wellington 20 November)?

PROMOTING A HEALTHY HOSPITAL ENVIRONMENT

Introduction

Fifty-five organisations and individuals (50% of submissions) made comments on Chapter Two of the *Framing Future Directions* discussion document. Many respondents expressed the view that this chapter is 'a positive and constructive summary of what needs to happen' (Association of Salaried Medical Specialists). The view was also expressed that 'effectiveness is limited because of limited resources to improve pay and conditions' (Medical Council of New Zealand).

The key themes identified include:

- trustworthy consultation with staff
- tools to support staff in the medico-legal environment
- the implementation of sound change management processes
- data requirements for workforce information
- training and development of staff
- the implementation of workforce research.

Stakeholder participation

Consultation with staff

Many respondents commented that trustworthy consultation with staff is an important component of stakeholder participation within an organisation. Crucial to the relationship process is 'joint clinical-management leadership … command and control management needs to be replaced with a commitment to a process of shared learning and exploration, which allows sustainable solutions to emerge' (Waitemata DHB).

> 'Consultation processes need to facilitate staff input, e.g. not just require written submissions, but provide feedback opportunities through focus groups, one to one feedback, etc … The relevance of the information to staff needs to be clear. Language used in documents needs to be as "jargon-free" and as unambiguous as possible. Implementation processes need to be transparent and well publicised, and responsibilities, timelines, etc be clearly identified' (MidCentral DHB).

However, management should 'only consult on the issues that they are prepared to listen to and implement the feedback' on (Auckland DHB) to give the process credibility. Credibility can be achieved by 'publishing the information gained from such a consultation and then the resultant actions. Once this process has been seen to be transparent and real, then more staff will come on board, giving more staff the feeling of ownership' (New Zealand Institute of Medical Radiation Technology).

It is also important to have staff representation at management level 'within the hospital so that all employees feel they have a voice and then can have a sense of ownership and responsibility' (The Royal Australia and New Zealand College of Obstetricians and Gynaecologists).

Supportive workplace culture

Teamwork

Some respondents commented on the important aspects of hospital culture, particularly the 'participation, collaboration, communication and emphasis on relationships that will provide a positive hospital environment in all aspects of work. Leadership or management must ... use ... these aspects in their everyday work. Teamwork, trust and goodwill are underlying concepts staff must believe in order to make a positive contribution' (Disabilities Resource Centre).

The benefit of all staff being able to 'enter into the communication process, [is that] there is more acceptance and understanding of the decisions made. Mutual respect comes from listening to other people's points of view and recognising their area of expertise' (New Zealand Institute of Medical Radiation Technology).

A number of respondents commented on the importance of the 'culture' of a hospital in the development of relationships. It is thought that 'management needs to be aware of the dominant culture and groups within hospitals and the influence and limits they can have on the ability of non-dominant groups to affect change. A consumer-focused or whole-systems approach as opposed to a facility or provider-based approach is useful in breaking down power differentials (New Zealand College of Midwives). More specifically, the 'WAIRUA of an organisation is important. The connection the organisation has with the people of the land (tangata whenua) and relationships are important' (Lakes DHB).

Staffing needs – valuing staff

Some respondents commented that hospitals should be aware of their staffing needs in order to improve staff morale. 'Staff need to be rewarded by appropriate remuneration' (New Zealand Medical Association), as 'high student loans, the higher salaries overseas and the lack of movement in salary levels in DHBs are major contributors to loss of staff' (New Zealand Society of Physiotherapists).

Others commented that staff need 'equitable continuing education funding, career structures, research opportunities' (Dietitians Board), 'rosters and duties that best suit an individual and more importantly family and whänau' (Stephen Lomax), and that 'time needs to be allocated in order that staff can fulfil their present "non-clinical" responsibilities' (Association of Salaried Medical Specialists).

> 'When hospitals are aware of "issues" [positive and negative] affecting the well being, service provision and job satisfaction of staff, they will be able to plan in advance of problems developing and becoming a cumulative stranglehold on their operational management and function' (Podiatrists Board).

Several respondents commented on the importance of valuing diversity in the workplace. It is generally held that 'in order for staff to feel valued, the clinical, professional and scientific skills of staff need to be acknowledged' (The New Zealand College of Clinical Psychologists), as well as Mäori concepts such as aroha, tika and pono (Lakes DHB).

It was suggested that, for this chapter to be more inclusive, the heading could be reworded to '… a healthy health-care environment', or 'promoting a healthy environment for health care workers' or similar. This would better include community and NGO organisations (Auckland DHB).

Medico-legal environment

It was commented that it is important that all staff are 'able to be confident of where they stand when a medico-legal issue arises. This can be done through education, and a clear set of organisational guidelines that establish what happens when an event occurs' (New Zealand Institute of Medical Radiation Technology). It was suggested that staff should have 'compulsory meaningful training and education on obligations under legislation such as the Privacy Act, Health and Disability Commissioner Act and other legislation' (Hawkes Bay DHB).

Most stakeholders commented that policies and guidelines which enable staff to be supported in the medico-legal environment.

> 'Have clear policies, guidelines and pathways that encourage staff to follow evidence-based best practice. If mistakes occur, encourage a "no blame reporting system" so incidents are reported and, where the mistake is a result of a system failure, have procedures in place that enable all staff to learn from the mistake. Clinicians [need] to be supported by management when mistakes occur, and both parties to work to introduce safer systems to reduce the potential for future errors to occur' (Pharmaceutical Society of New Zealand).

Magnet hospitals

There is support from the nursing sector for the adoption of the standards and principals of 'magnet' hospitals, as a tool to develop healthy hospital environments.

> 'Magnet hospitals are those that show excellence in management philosophy and practices of nursing services, adhere to standards for improving patient care, leadership of the nursing administrator in supporting professional practice, continued competence of nurses and attention to the cultural and ethnic diversity of patients [and] their families as well as [to] care providers in the system' (Auckland DHB – Nursing).

Change management

Management processes

There is strong support from most stakeholders, particularly District Health Boards, for the implementation of sound change management processes. Changes should only be introduced after consultation with staff affected, and only if there are clear benefits of the change ... preferably based on "best practice", and introduced where existing practices clearly do not meet best practice' (Pharmaceutical Society of New Zealand). Involving affected staff at an early stage is seen as important as 'change is accepted if staff can recognise it as an improvement' (School of Health Science, Unitec).

Therefore, it is important to 'ensure they use sound management methodology, have transparent processes, "real" consultation processes, involve all relevant stakeholders and unions from the outset, change management activities must be congruent with organisational values' (MidCentral DHB). It was suggested that 'formal quality management systems such as ISO 9001 provide an excellent framework for change' (Royal Australian and New Zealand College of Obstetricians and Gynaecologists New Zealand Committee). It is felt that 'both clinicians and managers need to be trained in change management' (Christchurch School of Medicine).

It was also suggested that stability within the health sector could be reached through 'multi-partite agreement amongst our politicians to maintain basic organisational structure of the health services ... then smaller changes can be made to increase efficiencies of the health services without major disruption and cost and health workers would not feel like pawns in the battles of politics' (New Zealand Dietetic Association).

Know your staff

Data requirements

Most respondents, particularly District Health Boards, commented that information collection at an organisational, regional and national level would give a comprehensive view of the workforce. It was stated that 'better information and analysis is a prerequisite if the sector is to make headway in workforce planning' (Capital Coast DHB). Specifically,

> 'Information should be collected at an organisational level and compiled both regionally and nationally. To give the most accurate "picture" of the workforce, organisational data from private sector and non-health organisations employing health professionals needs to be included ... This would include information such as demographics, trends, and ethnicity data' (MidCentral DHB).

It was also suggested that the data could be utilised by sharing it with 'staff, unions and professional associations' (New Zealand Association of Occupational Therapists) and that the 'information could allow for benchmarking of services or practices between hospitals' (Pharmaceutical Society of New Zealand). Others suggested that projects, such as the 'Mental Health Workforce Data Project' (Lakes DHB) and the 'National Nursing Workload Measurement Research' could be utilised (Nurse Executives of New Zealand).

Grow your staff

Work-based training

Many respondents, particularly District Health Boards, commented that 'work-based training is an important aspect of staff development to give staff the opportunity to develop a career in health' (Waikato DHB). It was important to:

> 'Ensure all hospitals have effective orientation, mentorship/preceptorship and education/training programmes in place. Personal development must also be considered, not just training related to area of practice' (Hawkes Bay DHB).

Others commented that 'collaborative learning for clinicians and managers' should be considered (Waitemata DHB) and that equity of training and development opportunities is important (School of Health Science, UNITEC).

Training of overseas doctors

Some of the respondents suggested that doctors who were trained overseas need to be trained in cultural competencies.

> 'Overseas-trained doctors need orientation and induction to help [them] adapt to the New Zealand health care system' as they 'do not have the same knowledge and recognition of New Zealand cultures, mores, values and beliefs, which all impact on how a health service is provided' (Medical Council of New Zealand).

Implementation

Workforce research – resources for implementation

Some respondents, particularly District Health Boards suggested that research and data collection would assist in the evaluation of staff morale, particularly the use of 'culture surveys, recruitment and retention statistics, patient outcomes, reduced staff absence and turnover statistics, monitoring staff participation in professional development, and suggestions for innovation' (Lakes DHB). Data such as 'increases/decreases in sick leave/annual leave tell a lot about how staff are feeling' (Royal New Zealand Plunket Society).

Another respondent suggested that there could be a 'Healthy Hospital' "scorecard" which would collect scores under three headings: 'Happy Healthy Hospital', 'Participatory and Democratic Decision Making', and 'Supportive Workplace Culture'. Staff representatives would complete the scorecard, which 'would be in the public domain, and be required reporting to the Minister by DHBs' (Association of Salaried Medical Specialists).

Other respondents suggested that developing a partnership with the community where time and resources are shared is important (Waitemata DHB), as 'many small organisations that are funded by DHBs to provide services do not have the resources' (New Zealand College of Midwives).

Consultation with staff

Some respondents suggested that consultation and involvement from staff could ensure the implementation of healthy workplace principles. For example, 'any implementation should involve staff, get champions on board and let them sell it to their colleagues' (Royal New Zealand Plunket Society). Others suggested that '"buy in" from management, consultation with staff, resultant actions and goals' are useful principles for the promotion of a healthy workplace environment (New Zealand Institute of Medical Radiation Technology).

Consultation meetings

Most of the participants at the consultation meetings, hui and fono made comments on the promotion of a healthy hospital environment similar to those in the submissions. Comments were made on:

- consultation with staff
- a supportive medico-legal environment
- the valuing of staff
- the 'magnet' concept
- communication of the change management processes
- data collection at a national level
- work-based training and career development
- training of overseas health workers
- research to assist in the evaluation of staff morale.

Participants also voiced some new ideas at the meetings. These include:

- 'recognition of excellence – what works' (Auckland 6 November)
- 'impact of the private sector on the public sector, such as waiting lists' (Christchurch 27 November).

EDUCATING A RESPONSIVE HEALTH WORKFORCE

Introduction

Seventy-two organisations and individuals (65% of submissions) made comments on Chapter Three of the *Framing Future Directions* discussion document. The key themes identified include:

- intersectoral collaboration in health workforce education
- defining and developing scopes of practice
- implementation of generic competencies
- collaborative research in the health and education sectors
- implementation of accessible educational programmes.

Alliances and connections in the health sector

Intersectoral collaboration

There is strong support from stakeholders, particularly District Health Boards for greater intersectoral collaboration in health workforce education. It was stated that 'it is essential that there is sharing between all the key players of the District Health Boards, tertiary institutions and the professional bodies that oversee the workforce' (Canterbury DHB – Mental Health Services). Increased levels of collaboration would 'ensure "work-ready" and competent graduates are fed into the workforce at regular spacing' (New Zealand Institute of Medical Radiation Technology).

Collaboration needs to be developed at a national level to 'ensure a better understanding of the environment and its requirements' (Lakes DHB), although it was noted that 'there appears to be no national co-ordinating body for this such as was present in the Health Workforce Development section of the previous DOH' (Clinical Leaders Association of New Zealand).

The role of the Clinical Training Agency (CTA) in workforce development was raised by a number of stakeholders. It was suggested that the agency should 'develop longer term partnerships with the sector to allow for smarter workforce development in areas of shortage' (Christchurch School of Medicine) although it was also stated that 'CTA funding has markedly improved employers' willingness to train rather than import staff' (Australian and New Zealand College of Anaesthetists).

Funding of education programmes

Some respondents, particularly from the nursing sector, commented that funding of education/training programmes for health professional groups is inequitable and that 'an education strategy must be developed that identifies a transitional pathway to ensure that historical funding anomalies are corrected' (New Zealand Nurses Organisation). While 'the notion of teaching hospitals with integrated clinical schools … has worked in many countries for many years, [in New Zealand] 'clinical teaching infrastructures are vulnerable to pruning…and many medium, provincial and rural hospitals have little or no resource because of the 90s dismantling of nursing infrastructure' (Nurse Executives of New Zealand).

> 'Each hospital supports the transition of the nurse from the newly graduated to the fully functioning Registered Nurse. Hospitals finance this themselves. The financial restraint placed on nursing budgets means many hospitals are unable to provide the preceptoring and non-clinical days needed to ensure this group of nurses receive adequate support, to both keep them in the workforce and ensure they function at a safe level' (Department of Nursing, Christchurch Hospital).

Others commented that the Clinical Training Agency funding process is inequitable in terms of funding for clinical placements and that:

> 'there are tensions between the CTA funding process and identified workforce planning needs. An example is the recognition by the Ministry of Health that recruitment and retention strategies are essential versus the lack of ongoing funding for New Graduate Nurse Programmes. These programmes should not have to be entirely funded by each DHB when the need is created by the education system not providing work-ready graduates' (Canterbury DHB).

It was suggested that agency funding 'needs to be split more equitably between disciplines taking account of the numbers of people within each professional group (Nurse Education in the Tertiary Sector). This could be achieved by giving it more resources and [putting it] under instruction to look at ways in which it can provide training for non-doctors and non-nurses' (New Zealand Association of Occupational Therapists).

Scopes of practice

Defining and developing scopes of practice

The importance of defining or clarifying the term 'scopes of practice' was noted by a number of respondents, as it is 'creating confusion' (New Zealand Nurses Organisation). Respondents felt that the 'clear articulation of scopes of practice of all health professionals will prevent speculation about what others do' (Hawkes Bay DHB) and 'contribute greatly to the health workforce. It will give employers with vastly different needs greater flexibility, and assist with retention by offering career options to employees (Waikato DHB). Providing a 'clear idea of who should perform tasks, … why [and] in what settings … is crucial as care workers should not be providing invasive interventions without clinical education or supervision' (Healthcare of New Zealand).

> It was suggested that 'there needs to be a close liaison between professional bodies, registration boards and the education providers to form a proposal for change [establishing] … the benefits to the patients' continuum of care, … the benefits to the health workforce as a whole, and [to] scope the competencies and related education required to perform the task' (New Zealand Institute of Medical Radiation Technology).
>
> Collaborative 'research projects would be an effective way of facilitating and evaluating changing workforce competencies within scopes of practice' (Auckland University of Technology).

It was noted, however, that the 'introduction or expansion of scopes of practice [would require] evaluation of its impact on the current workforce, financial implications and ensuring that public safety is preserved or improved' (Australian and New Zealand College of Anaesthetists).

Health education is a 'powerful force in shaping of scopes of practice' (The New Zealand Association of Occupational Therapists), and in order to have 'effective collaboration in health workforce education there need to be the same entry-level competencies' (New Zealand Dietetic Association).

Competencies of health practitioners

Generic competencies

There is general support from District Health Boards, professional associations/bodies and the education sector for generic competencies. The development of generic competencies could assist in the 'breaking down of professional silos' (Bay of Plenty DHB) by assisting in 'providing a foundation for communication [and] negotiation' (Canterbury DHB).

District Health Boards are particularly positive about generic competencies:

> "The CanMEDs report has identified a broad range of competencies required by all health professionals of the future, beyond expert decision-making and procedural skills. These competencies include communication, leadership, advocacy, management, research and teaching etc' (Waitemata DHB).

Generic competencies are seen as being particularly relevant to the rural workforce where 'the workforce is small and recruitment of specialised practitioners is difficult … [and already] … some "generic activity" is being delivered by resident practitioners' (The Institute of Rural Health). Resources 'can be shared easily if trust relationships exist and there is a low level of territoriality' (Anonymous – Iwi Provider). Lakes District Health Board stated that 'generic competencies in health workforce education are important as long as they all include Mäori Health competencies also'.

The development of generic competencies 'is a huge opportunity to minimise duplication … because everybody needs development in the behavioural competencies and to a certain level in some of the technical competencies' (Waikato DHB).

> 'Generic components are important across health workforce education to develop the basis for which specialty practice can occur. Everyone needs components such as communication skills, working as team member, working with clients, cultural safety and community involvement no matter [what] their role' (Royal New Zealand Plunket Society).

Professional associations/bodies generally support the establishment of generic competencies, but with clear definitions. For example, 'although components of education programmes may be generic across disciplines, the competencies of the health practitioners on registration should be specific to that discipline' (Nursing Council of New Zealand). It was also commented that there is a 'need for consultation about what they are' (Psychologists Board, Workforce Committee).

The education sector has mixed views about generic competencies. On the one hand 'generic competencies are conceptualised ... as an integral component of practice for all health workforce practitioners ... All members of the health workforce ought to be competent in dimensions of practice within the contemporary socio-political environment ... The Faculty believes generic competencies to be relevant at the global level, such as communicating effectively with consumers and team members, and service based, such as competencies for mental health practice' (Auckland University of Technology). On the other, 'members do not agree that there is a place for generic; this erroneously assumes that competencies can be separated from the context of their application' (Nurse Education in the Tertiary Sector).

Type of course

Some respondents support the concept of teamwork being a basic 'requirement of all health practitioner education' (Pharmaceutical Society of New Zealand). Others suggest that:

> 'incorporation of cultural training in day-to-day practice at all levels of training ... because it receives greater emphasis and increases the chances of improved recognition of other cultures' mores and [of] improving the communication and understanding between practitioners and patients, leading to better provision of health services' (Medical Council of New Zealand)

Lakes District Health Board agrees by suggesting that 'Mäori models of practice' be incorporated into training programmes (Lakes DHB).

Specialist competencies

There is strong support for specialist competencies, particularly from professional associations/bodies and the educational sector. Specialist training should be at postgraduate level, following the mastering of the basics, as 'a practitioner must first demonstrate competency in the generic competencies before seeking to undertake a higher-level scope of practice' (Pharmaceutical Society of New Zealand).

> 'Two years of general hospital experience post medical degree graduation before commencing specialist training and anaesthesia is crucial to giving trainees a background of knowledge and skills that are essential for the development of well-rounded anaesthetists. Specialist training should not commence until basic training has been completed and the trainee has worked for a suitable period in the workplace. This fits with the flexibility required of the healthcare workforce in New Zealand, where the majority of hospitals require generalist type, broad skills' (Australia and New Zealand College of Anaesthetists).

However, '[generic and specialist competencies] should not be seen as existing in a linear relationship, but as being interrelated and interdependent (Auckland University of Technology).

Learning institutions

Collaborative research and development

There is strong support from all stakeholders for the collaboration of research and development projects in the health and education sectors. For example, 'combined education and health service research teams can be fostered by close relationships and mutual governance of education programmes' (Unitec, School of Health Science). Others suggested that practitioners could be involved 'in all aspects of research' (Marion Poore) and that research should be 'linked to health strategies and priorities' (Auckland DHB – Nursing).

However, 'the current workload for most GPs prohibits [all] but a few being involved in research. In order to foster GP research there is a need to resource protected research time for general practitioners' (Royal New Zealand College of General Practitioners).

Professional development of educators

The New Zealand Medical Association stated that 'it is an ethical and professional responsibility of doctors to pass on their knowledge to students. The nub of medical education is providing an environment that facilitates and supports this process in formal and informal ways'.

This position is reflected in the strong support for developing the teaching capability of educators. It was suggested that the 'teaching capability of staff can be strengthened by ensuring that learning organisations offer workforce development opportunities, such as "train the trainers"' (Family Planning Association).

'In order to be an educator, workplace staff require funding, support and access to continuing education, so they in turn can better facilitate student learning ... Teaching staff to educate others should be seen as core business' (New Zealand Institute of Medical Radiation Technology). Other respondents feel that understanding adult learning concepts could 'be considered as a generic competency for all health professional training programmes' (MidCentral District Health Board).

Joint appointments

Some respondents suggested that there could be 'joint appointments and memorandums of understanding between the institutions' (New Zealand Institute of Medical Radiation Technology).

> 'Joint academic and practice appointments have the potential to improve the link between practice and research. Professional groups based in the primary sector should be considered by DHBs and academic institutions when considering such appointments' (New Zealand College of Midwives).

Attraction and retention in education programmes

Accessible programmes

Some respondents commented that there should be more accessible educational programmes through a range of media such as 'distance education and E-learning', and 'local and regional solutions' (Whitireia Community Polytechnic, School of Nursing and Health Studies). The key attribute of such programmes is flexibility.

It was also suggested that 'education needs to be designed in consultation with the range of communities in New Zealand – rural, urban, Mäori, mainstream' (Anonymous – Iwi Provider).

> 'Plunket has developed, and delivers, a graduate diploma course [which is] being delivered in a polytechnic by a multicultural team, [and which] demonstrates a model of partnership and collaboration. The course attracts increasing numbers of Mäori, Pacific and rural students. As a 'distance course' it allows participants to work in their own community with their own people' (Royal New Zealand Plunket Society).

Targeting students

Some respondents suggested that there could be a recruitment strategy to promote health as a career to students. District Health Boards 'need to develop a collective approach to promotion in schools and tertiary institutions and to follow this up with a broader communications strategy' (Capital Coast DHB).

'Discussions with college 6th and 7th formers and career advisors have indicated that a career within the health field has less appeal than other mainstream occupations ... The perception is that hospitals have only two occupations, doctors and nurses. Boys automatically assume that nursing is a "girls only" occupation and, for both genders, gaining entry to medical school demands consistent top grades, which rules out another significant proportion of the student population' (Northland District Health Board – Te Poutokomanawa/ Mäori Directorate).

Student loans

A few respondents commented that the issue of student loans should be addressed. For example, 'strategies must be found to address the student debt issue' (Royal New Zealand College of General Practitioners) and 'some form of student debt retirement or alternative but effective arrangement is vital and urgent' (Association of Salaried Medical Specialists). However, it is perceived that bonding schemes are 'inappropriate' and 'potentially harmful for students' (New Zealand Medical Students Association).

Consultation meetings

Most of the participants at the consultation meetings, hui and fono made comments on the education of a responsive health workforce similar to those in the submissions. For example, comments were made on:

- intersectoral collaboration between the education sector, health sector and professional organisations
- funding of education programmes
- the evolvement of scopes of practice
- the value of generic training, e.g. teamwork
- the emphasis on specialist competencies at an post-graduate level
- an collaborative research environment
- the professional development of educators
- access to education
- recruitment strategies to target students
- the impact of student loans.

The participants voiced several new ideas at the meetings. These include:

- exit times from different courses could be staggered to help with clinical placements and the introduction of re-entry courses for all health professionals (Wellington 20 November). Please note this idea had little mention in the submissions.
- the impact of the Tertiary Education Commission report on research funding and relevance (Auckland 6 November).
- recognition of the private sector as a training provider (Hamilton 12 November).

BUILDING MÄORI HEALTH WORKFORCE CAPACITY

Introduction

Fifty-four organisations and individuals (49% of submissions) made comments on Section Four of the *Framing Future Directions* document. The key themes identified include:

- factors crucial to Mäori workforce development
- the establishment of a national Mäori health workforce organisation
- career pathways for Mäori
- the development of Mäori-led research
- collection of Mäori health workforce data by District Health Boards
- development of the allied health workforce
- a marketing strategy to recruit Mäori.

Context and trends

Crucial factors

Some of the respondents identified factors crucial to Mäori workforce development. These include:

- 'the contextual infrastructure in which Mäori operate' such as housing and education (Waikato DHB)
- 'the needs of rural Mäori' have not been identified, such as support and professional development for Mäori health professionals (Anonymous – Iwi Provider)
- lack of support for education within a cultural context, e.g. 'Mäori models of practice and models of teaching and learning' (New Zealand Association of Counsellors)
- the issue of discrimination of Mäori employees, i.e. 'the minimal numbers of Mäori in decision-making roles' (Psychologists Board, Workforce Committee)
- the 'vulnerability to changes in government policy and funding practices that enable funding inequity' (Waitemata DHB).

Development of national leadership and strategy

A national organisation

There is overall support from all respondents for the establishment of a national Mäori health workforce organisation, which could be 'facilitated nationally but delivered regionally' (New Zealand Nurses Organisation – Midland).

> 'A national organisation led by Mäori [would] be totally dedicated and sensitive to the issues and needs of Mäori workforce development. The organisation could also lead the implementation of a national vision and strategy for Mäori health workforce development across the many stakeholders that contribute to workforce development' (Hauora.com Trust).

It was suggested that a model for the development of such a 'health workforce development strategy' could be provided by *'He Korowai Oranga'* (Lakes DHB – PHO Contracts).

Specific initiatives

A few respondents commented that 'specific initiatives for the development of Mäori must be included in any workforce planning and development' (Ministry of Health, National Screening Unit) and that 'buy in from influential Mäori' could assist in 'providing leadership' for this development (New Zealand Institute of Medical Radiation Technology).

Intersectoral collaboration

It was suggested that there could be increased collaboration in workforce development between the health and education sectors. In the Waikato a 'joint project with further research into understanding Mäori may result in a collaborative outcome to encourage Mäori rangitahi into tertiary study' (Waikato DHB).

Treaty responsiveness

Some respondents commented that 'the Treaty Responsiveness Framework' could identify Mäori health workforce issues across services (Hawkes Bay DHB) and that the 'principles of partnership, participation and protection should be promoted to achieve collaborative service delivery and governance' (New Zealand College of Midwives).

Working with employers

Career pathways

Respondents supported 'the development of career pathways for Mäori in clinical, education, research and management practice' (Te Runanga-O-Kirikiriroa). It was suggested that District Health Boards 'need to actively train current Mäori staff as well as recruit well-qualified Mäori staff' (Northland DHB – Te Poutokomanawa/Mäori Directorate). Auckland Regional Public Health Service 'has recruited, retained and developed a high proportion of Mäori staff' (Auckland DHB – Regional Public Health Service).

It was also suggested that career pathways 'would provide an entry point for people who do not have an educational background to undertake tertiary training', through entry-level roles such as Health Care Assistant and Community Worker (Capital Coast DHB).

Mäori preferred-employers

Some respondents commented that the development of Mäori preferred-employer criteria 'would provide a more acceptable and inviting work environment, raise the work satisfaction of Mäori staff, and assist employers in Mäori staff retention' (Lakes DHB).

Recognition of Mäori-specific skills

A few respondents commented that employers should recognise Mäori specific skills by offering 'specific remuneration packages for Mäori-specific skills [such as] te reo, karakia, powhiri, [and the roles of] kaumatua and kuia' (Hawkes Bay DHB). It was suggested that the number of these roles should be increased in order to ease the pressure on existing Mäori staff 'to provide cultural advice as well as complete their own work' (Waikato DHB).

Mäori health outcomes

Several respondents commented that positive Mäori health outcomes would increase if the environment was responsive to the needs of Mäori.

> 'The priority of Mäori who work in the screening sector is closely linked with the participation of Mäori women in the screening programmes. It is presumed that health promoters who can identify with women they are wanting to enrol in the programmes, will relate to the women more easily and where necessary can communicate in the language of these women' (Ministry of Health, National Screening Unit).

It was also stated that 'Mäori community health workers' have access to communities that would often be "no-go areas" for other health professionals' (Te Runanga–O-Kirikiriroa).

Working with educational institutions

It was suggested that 'collaboration with tertiary institutions in marketing activities could encourage Mäori to train in health professions' (MidCentral DHB).

Capacity building on the basis of evidence

Mäori research

Some of the respondents, particularly iwi organisations and District Health Boards suggested that Mäori research could assist in the development of Mäori health workforce strategies. For example, 'Mäori units in universities and Te Wananga O Raukawa could be invited to establish a Mäori Health Research Unit' (Tuwharetoa Health Services), and that 'Te Rau Matatini led by Mason Durie and Paul Hirini at Massey University is a good model for enhancing Mäori capacity' (Janet Peters). It was also suggested that collaborative relationships with Mäori research units such as Eru Pomare and Te Pumanawa Mäori' could 'ensure that research ethics and dissemination of results are appropriate' (Hawkes Bay DHB).

It was also suggested that District Health Boards could 'employ a Mäori health researcher to scope and identify the Mäori health workforce within their region' (Lakes DHB). However, it was considered that 'researchers need to impart their knowledge to hapu/iwi groups to develop their capacity to do their own research' (Psychologists Board, Workforce Committee).

Mäori health workforce data

District Health Boards data collection

Some respondents, particularly iwi organisations and District Health Boards, suggested that District Health Boards should collect data using 'consistent templates for defining, collecting and analysing information [such as the] MidCentral model which was replicated by CDHB in 2002' (Canterbury DHB). It was suggested that the 'head of Mäori workforce development within DHBs would be responsible for this data' (Choice Health, Wairarapa DHB) and that 'a Mäori Health Research Unit would be able to act as Kaitiaki for the safe transfer and ownership of data' for use at central level (Tuwharetoa Health Services).

Role of the Ministry of Health

Some respondents commented that the role of the Ministry of Health would be 'to ensure that all District Health Boards use the same reporting template so that data collection is consistent' (Lakes DHB) and that the Ministry could define ethnicity categories 'as determined by Statistics New Zealand' (Royal New Zealand Foundation for the Blind). It was also suggested that the Ministry could act 'as facilitator of the framework for collection, definer of Mäori worker roles, funder, and monitoring agency' (Hauora.com Trust).

Education of the Mäori health workforce

Development of allied health practitioners

Some respondents identified allied health as the area of the Mäori health workforce that should have the highest priority for development 'given that there are proportionally fewer Mäori in allied health than other professions' (New Zealand Association of Occupational Therapists).

> 'Auckland District Health Board stated that 'Social workers are the only group (apparently) fairly represented in terms of the Mäori workforce ... Other allied health disciplines such as occupational therapy, physiotherapy, speech language therapy, dietitians and psychologists are all grossly under-represented in terms of Mäori staff' (Auckland DHB).

On the other hand, it was suggested that the mental health sector 'needs more Mäori psychiatrists, psychologists and psychiatric nurses as this is a high-needs area, and the need to understand Mäori Kaupapa Mental Health Services and associated Mäori Tikanga is vital for health outcomes' (Hawkes Bay DHB).

Other respondents commented that 'Health Care Assistants could be placed in the acute environment and Community Support Workers placed in the community, which may suit many Mäori' (Auckland DHB). Others suggested that nursing should be the priority, as it is 'easily attainable, portable, flexible' (Hauora.com Trust) and 'because they see and deal with the largest group of Mäori clients in primary health care settings' (New Zealand Nurses Organisation – Midland).

Career pathways

Some respondents commented that career pathways could be developed to assist Mäori into the health workforce. For example, 'start where the bulk of the health workforce is and introduce "staircasing" and career development as the UK is implementing' (Canterbury DHB). Others suggested that 'DHB providers and the Ministry of Health could assist with career pathway planning' (Lakes DHB), and the 'development of an mentoring programme with education institutions' would 'foster career pathways for Mäori' (Hawkes Bay DHB).

Needs analysis

Some respondents commented that a review of current training programmes would identify whether the needs of Mäori are being met.

> 'A review would identify barriers to entry to programmes, whether programmes and their delivery are culturally aligned, whether the programmes meet the needs of the Mäori workforce, whether additional or alternative programmes are necessary, and from this, recommendations would be able to be made about how improvements could be made' (MidCentral DHB).

Recruitment of Mäori health practitioners

A marketing strategy to recruit Mäori

Many respondents commented that there should be a multi-level approach for the recruitment of Mäori into health education and the health workforce. It was suggested that the government, i.e. the Ministry of Health, the Ministry of Education and Te Puni Kokiri, could resource marketing' (Lakes DHB). Others suggested that there should be a national marketing campaign, which could involve 'all key stakeholder agencies' (Psychologists Board, Workforce Committee), professional bodies (Hauora.com Trust) and iwi (Anonymous – Iwi Provider).

Role models

Some respondents suggested that role models could be used to promote health as a career. For example, use Mäori role models to visit schools (Hauora.com Trust). However, there are 'low numbers of Mäori health care workers, which puts pressure on the limited number of role models' (Whitireia Community Polytechnic, School of Nursing and Health Studies).

Targeting

Some respondents suggested that marketing strategies should target children from an early age into health careers. For example, health services should be marketed as 'career options to tamariki Mäori and their whänau from preschool to university' (Anonymous – Iwi Provider). Others suggested that Mäori students should be encouraged to choose 'the appropriate prerequisite qualifications' such as science subjects (Auckland DHB – Regional Public Health Service).

Consultation meetings

Most of the participants at the consultation meetings and hui made comments on building the Mäori health workforce capacity that were similar to those in the submissions. For example, comments were made on:

- the development of a national strategy
- collaboration between education, health and iwi
- career pathways
- workforce environments that are conducive to Mäori
- Mäori approach to health and health outcomes
- the collection of consistent workforce data
- career pathways in education, e.g. staircasing
- training packages that include Mäori knowledge
- role models to promote health as a career
- targeting students at an early age.

The participants voiced a number of new ideas at the meetings. These include:

- a communication strategy about what Mäori are achieving (Rotorua hui 3 December)
- 'increase the community development model, e.g. "educate the whänau"' (Rotorua hui 3 December).
- 'the key is community support. It's the ordinary person that we need to protect and upskill. More money needs to be spent on community development as opposed to community health development. Importance of Whakawhänaungatanga – working together' (Auckland hui 6 November)
- medical students, nursing students and dietitians going to schools to promote health as a career for Mäori. There has been a good response, as it has made pupils aware of possible careers in health (Christchurch hui 4 December).

BUILDING PACIFIC HEALTH WORKFORCE CAPACITY

Introduction

Forty organisations and individuals (36% of submissions),[2] particularly professional associations/colleges/bodies and District Health Boards, made comments on Chapter Five of the *Framing Future Directions* document. The key themes identified include:

- factors crucial to Pacific workforce development
- career pathways for Pacific peoples
- responsive teaching methods in education and training
- capacity building of managers and clinicians
- a strategy to recruit and retain the Pacific health workforce.

Context and trends

Crucial factors

Some of the respondents identified a number of factors crucial to Pacific workforce development. These include:

- the 'lack of acknowledgement that the Pacific Island community is made up of many smaller communities' (Waikato DHB)
- 'low socioeconomic status of Pacific peoples' impacts on their ability to afford education and training (Psychologists Board, Workforce Committee)
- 'some Pacific peoples see nursing and community health work as low- status occupations' and instead prefer medicine, law etc (Anonymous – Iwi Provider)
- 'additional research into the mechanisms of the barriers that have been identified may be required' (Medical Council of New Zealand).

[2] Please note: Some of the comments in this section were made in Section Four, i.e. respondents reported on 'Mäori and Pacific' and the comments have been reflected in both chapters. Thus, in some cases the words 'Pacific peoples' have been substituted for the word Mäori.

Support for Pacific peoples to pursue a health career

Career pathways

Some respondents commented that career pathways are essential to the development of the Pacific health workforce. For example, there are a 'lack of pathways into the New Zealand workforce and a lack of organisational support' (Lakes DHB – PHO Contracts). It was also noted that there is a 'lack of bridging programmes for Pacific peoples coming to New Zealand due to costs associated with relocation and re-registration' (Waikato DHB).

Some respondents suggested that 'mentoring by key Pacific peoples in the health environment' (Hawkes Bay DHB), internships (Family Planning Association New Zealand), and 'personal role model initiatives' (Canterbury DHB) are very effective strategies to encourage Pacific peoples into a career in health.

Working with the community

Several respondents commented that working with community leaders could attract Pacific peoples into a health career. For example, involve 'Pacific leaders such as pastors, matai, Pasifika, in recruiting Pacific people for information sessions about health as a career' (Anonymous – Iwi Provider).

Development of the education sector

Responsive teaching methods

Some respondents commented that responsive teaching methods are needed to ensure active participation of Pacific peoples in education.

> 'By using culturally specific teaching and assessment methods ... Through the Pacifica people – they need to be involved in the development of the competencies and in the teaching of these ... Good models exist for Mäori cultural competencies and these models could be used as examples to develop similar models for Pacific peoples' (Lakes DHB).

Best practice guidelines

Several respondents commented that the development of best practice guidelines 'along [a] Pacific nations focus as well as cross-Pacific would also be very valuable. A very inclusive process must be used for this to ensure wide buy-in' (Canterbury DHB).

Targeting students

Some respondents, particularly District Health Boards suggested that marketing strategies should target students at schools.

> 'Workforce development starts at school … Specific targeting will be required to demonstrate the value of tertiary training and a career pathway in health, not only for the individual, but also for the individual's family and their community' (Waikato DHB).

Pacific provider development

Capacity building of managers and clinicians

Some respondents, especially District Health Boards commented that investment in the Pacific provider environment will develop the Pacific workforce clinical and management capacity.

> 'Investment in a vibrant, sustainable, quality Pacific provider environment will support Pacific clinical and management capacity because it will ensure career pathways for Pacific staff in appropriate cultural settings' (Canterbury DHB).

It was also suggested that there could be 'greater commitment from the business community to provide opportunities to Pacific peoples to gain skills and expertise that will be transferable in the health environment' (Waikato DHB).

Involving staff in planning

A few respondents commented that Pacific staff should be involved 'at all levels in a strategic plan for Pacific workforce development' (Anonymous – Iwi Provider).

Sharing knowledge between providers

It was suggested that 'additional schemes such as rotations can be investigated to ensure a sharing of knowledge between the Pacific providers and mainstream providers' (Lakes DHB).

Developing Pacific health policy and planning capacity

Recruitment and retention strategies

Some respondents commented that workplace strategies could assist employers in the recruitment and retention of the Pacific health workforce through the establishment of 'cultural support networks in the workplace' (Waikato DHB), and that the inclusion of 'the special needs of Pacific peoples in their context' (Royal New Zealand Plunket Society) were effective strategies. Pacific practitioners 'are under enormous pressure from their own communities, their professions and their employers' because of 'the poor performance of the New Zealand system in recruiting, training and retaining' Pacific peoples (Association of Salaried Medical Specialists).

Consultation meetings

Most of the participants at the consultation meetings and fono made comments on building the Pacific health workforce capacity that were similar to the comments in the submissions. For example, comments were made on:

- career pathways
- responsive teaching methods, that is, valuing cultural knowledge
- investment in the Pacific provider environment
- Pacific peoples determining the design of the workforce
- retention strategies.

The participants voiced a number of new ideas at the meetings. These include:

- establishing a 'Pacific Workforce Development Group, which co-ordinates Pacific development activities [and] drives and monitors to ensure that progress is made' (Auckland 6 November)
- collecting information on the Pacific workforce (Wellington 20 November)
- 'funding tends to be short-term but development by its nature is long-term' (Auckland 6 November)
- 'family priorities come first for Pacific Island workers and career is second priority' (Wellington 20 November)
- it is important that Pacific peoples understand the system and that Pacific peoples are respected and understood (Wellington 20 November)
- there are medical school barriers at all levels, that is, at entry and in retention. There is a need to support mentors and support students in institutions because of the high failure rates (Auckland 6 November)
- there should be dedicated medical school positions for Pacific peoples, so they do not have to compete with Mäori (Auckland 6 November).

BUILDING THE HEALTH AND SUPPORT WORKFORCE CAPACITY FOR PEOPLE WHO EXPERIENCE DISABILITY

Introduction

Fifty-two organisations and individuals (47% of submissions) made comments on Chapter Six of the *Framing Future Directions* discussion document. The key themes identified include:

- the need for a role in the health and support workforce for people who experience disability
- clarification of the disability health and support framework
- intersectoral responsibility for the investment in disability education
- the implementation of a local needs assessment plan and a national stocktake of the workforce
- development of support worker training
- development of needs assessment and service co-ordinator training.

Context – barriers

A role in the health and support workforce for people who experience disability

Some of the respondents, particularly from the disability sector, commented that there should be a role in the health and support workforce for people experiencing disability.

> 'If we are really to remove barriers and promote participation in chosen activities and occupations, the health and education sectors should actively promote people experiencing disability becoming a significant component of the health and support workforce' (Auckland University of Technology).

Career pathways

Some respondents commented that low wages (Royal New Zealand Foundation for the Blind) and lack of career pathways create recruitment and retention issues.

> 'The health and support workforce for the disability sector is not adequately funded. Poor wages create recruiting and retention difficulties. The sector should not be classed as a 'poor cousin' to the health sector, but while the right calibre of people cannot be retained this belief will persist. People appear to "fall" into working in the disability sector – it is not seen or promoted as a career option' (Epilepsy New Zealand).

The health and support workforce

The disability health and support framework

There was general support from the stakeholders for the disability health and support framework being based on functions rather than levels of skill or disciplines. It was thought that 'this is a particularly useful model as it describes what the workforce needs to be doing rather than the qualification/preparation needed' (The Institute of Rural Health). However, a number of comments demonstrated that the framework is not well understood.

> 'This framework seems to address the functions that support workers would work within rather than a discipline which does not necessary cover what they actually do and how they support the disability sector. It should be recognised that the specialist groups do not exclusively work with disability but with a mix of clients. Why not consider a framework that utilises both functions and levels of skill?' (Lakes DHB).

It was also commented that 'there is no mention of Mäori concepts/context' (IHC) and that 'the tension between whether disability support is a medical or social service needs to be resolved' (New Zealand Federation of Vocational and Support Services).

Fostering a well-informed and responsive workforce for people experiencing disability

Intersectoral responsibility for the investment in disability education

Some respondents commented that there should be intersectoral responsibility for the investment in disability education for all health practitioners. For example, 'the main responsibility for this investment must be from central government and through the education sector with consultation from the relevant parties, such as PHOs, DHBs and the disability sector' (Lakes DHB). It was suggested that 'MoH and DHBs need to collaborate to design an awareness-raising campaign which gets disability information to all health practitioners, both students and those practising' (The Office for Disability Issues).

Participation of the disability community in service development

Some of the respondents commented that the disability community should participate in service development. For example, 'strong linkages between the "disability community" and health and education organisations need to be developed' (MidCentral DHB). It was also commented that 'family/whänau are integral to a strength-based model of care and should also be involved at all levels of education/health policy and advocacy' (SF Waikato – Supporting Families in Mental Illness, Schizophrenia Fellowship).

Mäori models of practice

A few of the respondents suggested that 'Mäori models of practice and Mäori concepts' should be integrated into the development of disability health services (Lakes DHB).

> 'The MH [mental health] Support Work model has provided opportunity for Mäori indigenous models of healthcare to be used for people/tangata whaiora with mental health needs, and for Mäori to become trained and professionally qualified members of the mental health workforce. It has [also] resulted in great opportunities and developments for Mäori and Pacific MH services, significantly increasing the numbers of Mäori and Pacific peoples as trained, qualified members of the mental health workforce, and allowing the delivery of service using customary/traditional practices that are acceptable and effective' (Mental Health Support Work Advisory Group).

Role of the disability advice co-ordinator

Some of the respondents, particularly District Health Boards commented that a disability advice co-ordinator could assist Primary Health Organisations to respond appropriately to the needs of people experiencing disability. For example, 'PHOs will deal with a significant proportion of the "disability community", and such a function will ensure that they are responding appropriately to that community's needs' (MidCentral DHB).

> 'Employment of a disability adviser/co-ordinator could assist PHOs to better meet the needs of disabled people. It would help bring some cohesion of service delivery at a local level for those disabled people who are high health service users, which include many older people. They could provide disability training to other staff of the primary healthcare organisations' (The Office for Disability Issues).

Career pathways

Some of the respondents commented that there is a need to develop career pathways for people experiencing disability so they can participate effectively in the health and education sectors. For example, 'people with disabilities consistently experience unmet needs in relation to tertiary education and achieving vocational careers, including joining the health and support workforce' (Auckland University of Technology).

> 'While disability occurs across all economic sectors, a useful focus might be on those that have not yet entered the working world [such as disabled youth], those who have left it and will not return, and those who have left and will return. Introduction of this analysis provides goals related to the integration and retention of disabled people into the economy' (Waikato DHB).

Disability training for the mainstream

Some of the respondents commented that disability training should be incorporated into all mainstream organisations, and that people experiencing disability should provide this training.

> 'Health training organisations, managers of health services and health workforce credentialling processes should invite and pay disabled people to have input into their curriculums etc and to provide information/training ... about disability issues. There could be requirements for employers or trainers to provide disability awareness information within standards and competency documents and also through funding contracts' (The Office for Disability Issues).

It was also stated that 'evidence from work done by IHC shows [that] increasing the knowledge and capacity of GPs has improved the health status and enhanced access to primary care, such as mammography and cervical screening' (IHC).

Development of the capacity of disability specialist workers

Local needs assessment plans

Some of the respondents, particularly District Health Boards and the disability sector, commented that local needs assessment plans could be undertaken at a DHB level. For example, there should be a 'thorough analysis of the needs identified by the workforce and by the patient/client population groups' (Auckland DHB).

> 'A disability needs assessment/census data will provide indicative data re levels and types of disabilities in each DHB. Depending on the number of people with specific types of impairments, specialist planning may have to be local, regional or national (DHBNZ)' (Lakes DHB).

Others commented that planning for specialist needs must be 'discussed with relevant professionals at DHB level' (Hawkes Bay DHB), and that 'consultation with appropriate national bodies' should take place as part of local planning' (New Zealand Association of Occupational Therapists).

National stocktake of the workforce

Some of the respondents particularly District Health Boards and the disability sector, commented that a national workforce stocktake could be undertaken. For example, 'DHBs need to collect information on demand and to undertake forward projections to anticipate demand and feed this information into national workforce planning co-ordination' (IHC).

> 'It is very important that some national review and planning around disability specialists is undertaken ... [and it is] a priority for MoH to lead some cross-sectoral national workforce planning for disability specialists. Using the DHB needs assessments, special education strategy, international benchmarks and review of actual numbers on a national basis will assist some better targeted workforce planning for disability specialists' (The Office for Disability Issues).

It was also suggested that there should be research into people's experience of the available services, to provide a bigger picture (Auckland University of Technology). However this task should not be the responsibility of DHBs, but 'remain at a national level' and 'eventually devolve to a national organisation of the community of disabled people' (New Zealand CCS).

Postgraduate opportunities for specialist workers

A few of the respondents commented that specialist postgraduate opportunities could be provided for health practitioners. For example, there is a 'need for post-graduate training opportunities across the disability sector, so that professionals with an interest in this area can gain additional skills' (Psychologists Board, Workforce Committee), and 'social workers who are working in the health and disability area should have access to post-graduate clinical training' (Health Interest Group, Aotearoa New Zealand Association of Social Workers). It was also stated that 'CTA need to be funding accredited programmes at postgraduate level so that those who are interested … have a way of getting a qualification' (Canterbury DHB).

Development of the support workforce

Support worker training

Some of the respondents, particularly the disability sector, commented that training should be provided for support workers. For example, 'education, health and disability support sectors must work collaboratively to ensure the design and delivery of training and national qualifications that are relevant and effective' (Mental Health Support Work Advisory Group).

> 'A nationally certificated home-based support workforce would benefit the home support worker and the person with disabilities. The payoff would be a workforce that has increased value and is more likely to stay in the workforce. It would also provide a measurable standard of core competencies and outcomes that would benefit people with disabilities and workers alike' (Ministry of Health, Disability Services Directorate).

Others commented that there should be access to training, and adequate funding for training. For example, for support workers 'assistance to attend training is a major issue, as is access to and involvement in ongoing formal supervision. We need to be realistic about the practicalities and costs' (Lakes DHB).

Valuing the support worker role

Some of the respondents commented that the support worker role could be more valued. For example, this could be achieved through 'mutual respect for the importance of each support worker role' (SF Waikato – Supporting Families in Mental Illness, Schizophrenia Fellowship), and 'improved systems and education' which will 'improve the mana and self-esteem of support workers' (New Zealand Association of Occupational Therapists). Others commented that there should be career pathways and increased wages for the support workforce (New Zealand Council of Trade Unions).

> 'It may not be appropriate to see them as unpaid carers being required to be supervised and regulated yet still receive no remuneration for their contribution … The role of the support worker workforce needs to be clarified and career pathways developed so there isn't any confusion over their role and that of clinicians' (Lakes DHB).

Intersectoral framework

Some of the respondents commented that there should be an intersectoral framework for the development of the support workforce, which could be the responsibility of 'The Ministry of Health together with other departments that fund disability support' (MidCentral DHB).

> 'The Ministry of Health, along with other departments that fund disability support should get together to find a workable way to do this … There is a need to be careful about professionalising the support workforce as this can (a) make them too expensive to employ and (b) mean they lose their community and person focus' (Lakes DHB).

However, it was commented that 'the framework needs to be developed … under the guidance of a sector advisory group in which it is important that disabled people have a leading presence' (The Office for Disability Issues). It was also suggested that 'the CTU Health Sector group is co-ordinating union participation in the intersectoral approach undertaken with aged care, and could undertake such a role across other parts of the health sector' (New Zealand Council of Trade Unions).

Developing the needs assessment and service co-ordination workforce

Training needs assessment and service co-ordination workers (NASC)

Some of the respondents suggested that the needs assessment and service co-ordinator worker should have a training programme 'MUST have specific training' (Canterbury DHB).

> 'NASC agencies play a key role and staff should have the necessary skills and training to complete assessments and undertake service co-ordination to a high standard' (Royal New Zealand Foundation for the Blind).

It was also suggested that the 'CTA (Clinical Training Agency) could support a national training programme', which needs to take into account the varied skill base of needs assessors (Auckland DHB). Others suggested that 'competencies required for NASC workers need to be defined' (MidCentral DHB).

> 'Some of the core competencies will be common to other groups in this workforce but the NASC workforce must be skilled in assessment of needs (ecological assessment, that is, the person in their environment), understanding the social model, knowledge of what is required to support a person develop independence and participate in the community, and specific skills in the design of packages of support necessary for individual need' (IHC).

Placement of the needs assessment and service co-ordination services

Some of the respondents commented that the NASC services could be placed within Primary Health Organisations 'and at the local community level, and be responsible for the coordination between health services and disability services' (Canterbury DHB – Mental Health Services).

> 'Social work (could) be the main profession for assessment and linking across the services and that the social worker does these functions for the consumer and their family. The pilot model that has been developed in Canterbury, COSE [Co-ordination of Services for the Elderly] where workers are placed with General Practitioners and managed by the DHBS seems to be an affective structure for meeting the needs of clients' (Health Interest Group, Aotearoa New Zealand Association of Social Workers).

Comments were also made that 'whether NASC should sit alongside PHOs may depend on future DSS decisions on younger people with disabilities and on the current intra- and intersectoral collaborative project' (Ministry of Health, Disability Services Directorate). Others commented that NASC agencies need to maintain working relationships with the community and providers. For example, 'NASC agencies must maintain regular relationships with local community health providers, especially services with a holistic approach to health services in their community' (Disabilities Resource Centre).

Consultation meetings

Most of the participants at the consultation meetings, hui and fono made comments on building the workforce capacity for people who experience disabilities that were similar to those comments stated in the submissions. For example, comments were made on:

- the usefulness of the disability health and support framework
- career pathways for people experiencing disability
- training on disability issues for the workforce
- a stocktake of the workforce
- skill development for specialist workers
- support worker training
- valuing of support workers.

The participants also voiced some new ideas at the meetings. These include:

- the development of intellectual disability and mental health services, as it is a 'growing area' (Hamilton 12 November).
- 'no point in training Mäori if no Mäori [disability] service to work in' (Christchurch hui 4 December).

OVERALL COMMENTS

There is overall support for the *Framing Future Directions* discussion document and the work of the Health Workforce Advisory Committee (HWAC). For example:

- Nelson Marlborough District Health Board 'welcomes the committee's document and considers that it provides a sound basis for further discussion and planning regarding the health workforce in New Zealand' (Nelson Marlborough DHB)
- 'it is a very important initiative seeking to address a legacy of "learning disabilities" within health system, including leadership/management development' (Clinical Leaders Association)
- 'we congratulate the committee on addressing the workforce implications of the Primary Health Care Strategy, Mäori workforce, Pacific workforce and workforce capacity for people with disabilities. This comprehensive coverage of workforce issues for meeting priority goals, and the population perspectives that formed those priorities, makes the paucity of attention to public health workers more remarkable' (Public Health Association of New Zealand).

Comment was also made that the workforce planning needs to be manageable to those involved. For example, 'NMDHB supports the mechanisms established by DHBs through District Health Boards New Zealand (DHBNZ). This mechanism will provide DHBs with support and direction and enable other parties in the sector to interact with the DHB sector in a co-ordinated way' (Nelson Marlborough DHB).

However, stakeholders raised a number of concerns. These include:

- the fiscal and resource implications of implementing the recommendations. For example, 'the capacity not just of the DHBs but also the MOH and the education establishments to undertake the work outlined within current resources cannot be underestimated. It is suggested that the next steps need to include specifics on numbers, skill mix and regional distribution and the inclusion of a clear timeline' (Canterbury DHB)
- the lack of a public health perspective. For example, 'consideration of public health workforce issues is a significant gap in the document and raises questions about the ability to plan for recruitment, training, retention and career development of the public health workforce' (Health Promotion Forum of New Zealand/Runanga Whakapiki ake i te Hauora o Aotearoa)
- the need to address current issues. For example, the committee needs to 'turn its attention to the current workforce crises and offer much needed transition solutions and advice' (Hospice New Zealand)
- the need for further research. For example, 'there is a need for further robust and ongoing research. [It] should involve a needs analysis of workforce training, education and responsibilities, plus a comprehensive evaluation of workforce and providers of disability services' competencies and best practice guidelines' (Ministry of Health – Disabilities Service Directorate)

- the need to address nursing shortages. For example, ‘while NZNO supports a principled approach to health workforce development, the urgent needs of the nursing workforce can not be disregarded’ (New Zealand Nurses Organisation)
- the lack of community input. For example, ‘it is important that this consultation has a consumer input with representation at all levels and committees, so that the whole process can be balanced between the workforce who provide the services and the people who will receive them’ (Epilepsy New Zealand)
- the lack of an older person’s perspective. For example, ‘we are disappointed that no specific attention is given to the care of older people in *Framing Future Directions*. In the health sector as a whole, there is a lack of understanding about ageing that needs to be addressed’ (New Zealand Council of Christian Social Services)
- the lack of alternative/complementary medicine perspective. For example, ‘whilst the discussion document allows for specific discussion on Mäori workforce development, Pacific health workforce, it does not specifically address Traditional Chinese Medicine (TCM) nor Complementary and Alternative Medicine (CAM) health workforces’ (New Zealand Association of Traditional Chinese Medicine Inc).

DRAFT RECOMMENDATIONS FOR HEALTH WORKFORCE DEVELOPMENT

Background

The purpose of the Health Workforce Advisory Committee (HWAC) is to:

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

Purpose of summit

The summit provides a venue for HWAC to present its consultation findings and to engage support for the next stage of health workforce development. This will continue the process of drawing different health stakeholders together to take joint ownership of development.

HWAC initiated consultation with stakeholders through the *Framing Future Directions* discussion document. This consultation indicated that there is general support for the HWAC three-pronged strategy for developing the health workforce, including:

- a person-centred approach, where the needs of a person are central to workforce development
- use of systems analysis to address the broad issues that impact on workforce development, such as workplace culture, education and regulation
- a planned and managed evolutionary approach to workforce development, which involves learning through experience and the involvement and participation of all stakeholders at all levels in leading and managing change.

There is significant support for many of the areas targeted for action, such as workforce information collection at national, regional and local levels, and collaboration between the health and education sectors. There are some concerns that HWAC's strategic approach is not sufficiently focused on particular workforce groups, and does not offer solutions for immediate supply issues. There is also concern about the lack of detail about implementation requirements, such as timeframes and identifying resources for investment in workforce initiatives.

There is urgency among stakeholders about the need for health workforce development. There is support for the use of processes that engage and involve all levels of the health sector, in collaboration with other sectors. There is considerable good will among stakeholders towards working together and being involved in the process of workforce development.

The summit provides an opportunity to harness this good will to reach agreement about the draft recommendations for health workforce development. These draft recommendations will carry on a momentum for change by building on the considerable progress that has already been made in some areas.

For the purposes of focussing discussion around implementation, this paper identifies the next tasks for health workforce development, and potential owners for these tasks. This provides a framework for debate and extends previous consultation to the next level, that of implementation.

The purpose of the summit is to refine and modify this framework. This may involve identifying some areas where further work is needed before agreement can be reached. The summit is intended to reach a consensus about the next tasks and who will carry these tasks forward to resolution. This action plan will form the basis of recommendations to the Minister of Health.

Draft recommendations

All of the following proposals may be modified to include input from the summit.

1) To address the health workforce implications of the Primary Health Care Strategy, HWAC suggests:

a) that the Ministry of Health:

1. continues to promote collaborative practice between health services and with the wider community, during the implementation of the Primary Health Care Strategy
2. identifies funding sources for applied research in workforce development
3. uses performance management, contracting and monitoring to ensure that DHBs implement workforce development

b) that DHBs and emerging PHOs:

1. have workforce development plans, which include sections for Mäori, Pacific and other high-need populations
2. consult widely with local stakeholders during the implementation of the Primary Health Care Strategy
3. prepare and promote policies and plans to support governance, clinical leadership and management functions
4. explore possibilities for making more effective and efficient use of existing workforce resources

5. actively promote public health, allied health, community health and early intervention strategies in PHOs
6. explicitly invest in components of workforce development, including ongoing training, support, teamwork, mentoring and leadership development
7. address the particular needs of community development staff, support workers and volunteers
8. use a broad range of incentives to attract health workers to rural and socioeconomically disadvantaged areas
9. establish close working links with local education and training providers
10. resource primary health research in relation to workforce development

c) that the Tertiary Education Commission:

1. takes into account the New Zealand Health Strategy and the New Zealand Disability Strategy in the negotiation of tertiary education providers charters and profiles
2. consults with HWAC and the Ministry of Health about emerging models of health practice and utilisation of health practitioners.

2) To progress the development of healthy hospital environments, HWAC suggests:

a) that DHBs:

1. develop their own workplace values and workplace development plans and strategies, to ensure:
   - facilitation of staff involvement in decision making
   - implementation and evaluation initiatives to foster an effective and supportive hospital culture
   - effective and trustworthy change management
   - effective communication and information collection so that hospitals understand their workplace and staffing needs
   - development of staff throughout their employment
   - staff are enabled to perform well and are rewarded appropriately
   - an efficient, well-designed physical workplace environment
2. these values and plans are applied through every area of the workplace
3. they explicitly prioritise and invest in workplace development, with a view to influencing recruitment and retention

b) that the Ministry of Health, in collaboration with HWAC and the professional bodies, supports, guides and monitors workplace development in DHBs.

3) To facilitate the evolution and further development of health workforce education, HWAC suggests:

a) that the Tertiary Education Commission, in consultation with the health sector, introduces governance mechanisms to ensure that:

1. there is collaborative teaching, planning and information sharing practice between the health sector and tertiary education institutions
2. teaching capability of staff, both academic and clinical, needs supporting and strengthening
3. generic competencies that contribute to team work, primary health and cultural methods of practice, e.g. communication skills and leadership, are developed for all undergraduate health education courses
4. research capacity is strengthened and more clearly linked with health service practice
5. work-based learning is strengthened, shortages in clinical and community placements are addressed, and access to a spread of programmes throughout New Zealand are maintained
6. health workforce education can facilitate changes in skill mix for different work groups
7. students and graduates are actively recruited from under-represented areas of the population, using wider criteria than academic excellence

b) that DHBs produce local research and development plans for the health workforce

c) that DHBs and other health employers strengthen their role as educators, in collaboration with education institutions and professional bodies

d) that the Ministry of Health in consultation with District Health Boards New Zealand (DHBNZ), HWAC and the regulatory bodies, develops a national workforce research framework.

4) To progress Mäori health workforce development, HWAC suggests:

a) that the Ministry of Health and HWAC, in consultation with the sector, assess the need to develop a National Mäori Health Workforce Development function

b) that the Ministry of Health provides guidance about consistency in data collection about the Mäori workforce

c) that the Ministry of Health, Tertiary Education Commission and training providers collaborate to:

1. undertake a review of how current foundation, tertiary education and other clinical training programmes contribute to the development of the Mäori health workforce
2. ensure consultation and participation with Mäori about integration between education and health providers

3. develop outcome-based incentives for tertiary institutions
4. further develop research on the Mäori workforce

d) that DHBs, tertiary education institutions and other training providers, in consultation with national agencies, including Ministry of Health and HWAC, collaborate to:

1. further develop second-chance health education initiatives, including work experience and internships, for Mäori
2. facilitate ongoing education and development for Mäori health professionals
3. facilitate focus groups and/or forums with Mäori to reach a consensus about what competencies need to be developed in educational and training programmes to enable health practitioners to better meet the needs of Mäori
4. develop and resource a marketing strategy to promote health and science as career options for Mäori

e) that DHBs:

1. include requirements for Mäori when they produce their local workforce development plans
2. develop 'Mäori preferred-employer criteria'.[3]

5) To progress Pacific health workforce development, HWAC suggests:

a) that the Ministry of Health and DHBs collaborate to ensure that the representation of Pacific peoples employed in DHBs reflects the representation in local populations, through:

1. analysis of the wider determinants of Pacific representation in the health workforce
2. targeted investment in Pacific health workforce development
3. development of career pathways to facilitate transition into health education
4. involvement of Pacific leaders to develop and implement strategies for Pacific health workforce development

b) that DHBs:

1. invest in developing the capacity of Pacific providers and practitioners
2. develop linkages between Pacific and mainstream providers, for example, rotation of staff
3. further develop organisational tools to address discrimination

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[3] This concept is an adaptation of the 'magnet hospital' concept, which looks at what conditions are attractive to nurses. See Chapter 4 *Framing Future Directions* discussion document for a description of 'Mäori preferred-employer criteria'.

4. integrate research and development about culturally effective practice into mainstream organisational behaviour

5. continue to develop Pacific models of care

c) that the Ministry of Education continues to develop educational institutions to ensure:

1. accessible career guidance at secondary school for Pacific peoples

2. development of culturally appropriate teaching and assessment methods

3. further development of Pacific cultural competencies and promotion of cultural experience in health education institutions

4. pastoral and mentoring support and guidance for Pacific peoples during health education and training.

6) To facilitate evolution and development of the health and support workforce to better meet the needs of disabled people, HWAC suggests:

a) that the Office for Disability Issues, in consultation with key stakeholders:

1. researches and implements a strategy to address the barriers to participation of people experiencing disability with disabilities in the health sector

2. develops mechanisms for targeting investment in disability workforce development

3. holds a workshop, or a series of workshops, to develop an agreed framework and a set of development initiatives for the disability support workforce

4. reaches agreement about who should be the "keeper" of the agreed framework and set of development initiatives for the disability support workforce

b) that the Ministry of Health, in consultation with the Tertiary Education Commission, ACC and DHBs, works to:

1. develop a programme of activities to enhance health practitioners' knowledge of, and responsiveness to, disability issues

2. involve people experiencing disability, and their families, in training of health professionals

3. investigate how evolving Primary Health Organisations (PHOs) can incorporate a disability adviser function in their structures and work collaboratively with needs assessment and service co-ordination (NASC) services and hospital-based assessment treatment and rehabilitation (AT&R) service

4. develop training and career development mechanisms for NASC workers

5. undertake local, regional and national reviews of specialist disability practitioners dedicated to meeting specialised needs associated with impairment.

APPENDIX ONE – SUBMISSIONS RECEIVED

Organisation	Name
	Frances Acey
	Harry Bradshaw
	Linda Caddick
	Allie Crombie
	Allison Franklin
	Leonie Gallagher
	Stephen Lomax
	Janet Peters
	Marion Poore
	David Sloane
	CD Smith
Anonymous – Iwi Provider	
Arthritis New Zealand	Lynne St Clair-Chapman
Association of Salaried Medical Specialists	Angela Belich
Auckland District Health Board	Karen Holland
Auckland District Health Board – Nursing	C/ Mary MacManus
Auckland District Health Board – Regional Public Health Service	Monica Briggs
Auckland University of Technology	Max Abbott
Australian and New Zealand College of Anaesthetists	C/ Vaughan Laurenson
Australian College of Sexual Physicians	C/ Nicky Perkins
Bay of Plenty District Health Board	Gordon MacKay
Bay of Plenty District Health Board – Nursing	Christine Payne
Canterbury District Health Board	Sue Chapman
Canterbury District Health Board – Mental Health Services	Health Professional Advisory Group
Capital and Coast District Health Board	Margot Mains
Care Chemists	Des Adams
Choice Health, Wairarapa DHB	Trish Morrison
Christchurch Hospital, Department of Nursing	Sue Hayward
Christchurch School of Medicine	G Ian Town
Clinical Leaders Association of New Zealand	Laurence Malcolm
Counselling/Mental Health Network Group	Romola McKay
Dental and Medical Councils of New Zealand	Sue Ineson
Dental Council of New Zealand	Janet Eden
Diabetes New Zealand	Sarah Thomson
Dietitians Board	Jane Cartwright
Disabilities Resource Centre	Maraea Ruri
Epilepsy New Zealand	Karen Covell

Organisation	Name
Family Planning Association New Zealand	Gill Greer
Greenlane Hospital, Home and Older Peoples Health	Kaye Dennison
Hauora.com Trust	C/ Kris MacDonald
Hawkes Bay District Health Board	John Peters
Health Interest Group, Aotearoa New Zealand Association of Social Workers	Brenda Cromie
Health Promotion Forum of New Zealand/Runanga Whakapiki ake i te Hauora o Aotearoa	Liz Stewart
Healthcare of New Zealand Limited	Sue Hope
Hospice New Zealand	Ann Martin
IHC	Suzanne Win
Joint Faculty of Intensive Care Medicine	Ross Freebairn
Lakes District Health Board	Cathy Cooney
Lakes District Health Board – PHO Contracts	Jeremy Mihaka-Dyer
Medical Council of New Zealand	Sue Ineson
Mental Health Support Work Advisory Group	John Wade
MidCentral District Health Board	Anne Amoore
Ministry of Education	Shelley Harrison
Ministry of Health – Disability Services Directorate	Lester Mundell
Ministry of Health – Mental Health Directorate	Barry Welsh
Ministry of Health – National Screening Unit	Helen Potaka
Nelson Marlborough District Health Board	Denise Hutchins
Nelson Marlborough District Health Board – Social Work	Judy Greer
Neurological Alliance of New Zealand	Peter Kennedy-Good
New Zealand Association of Counsellors	Beryl Allison
New Zealand Association of Occupational Therapists	Glenn Barclay
New Zealand Association of Optometrists	Lesley Frederikson
New Zealand Association of Traditional Chinese Medicine Inc.	Ming Zhou
New Zealand Audiological Society	C/ Maree Gunn
New Zealand CCS	Paul Gibson
New Zealand College of Midwives	C/ Alison Eddy
New Zealand College of Practice Nurses	Marion Guy
New Zealand Council of Christian Social Services	Kerry Dalton
New Zealand Council of Trade Unions – Service and Food Workers Union	Judith Byrne
New Zealand Dental Therapists' Association	
New Zealand Dietetic Association	Ms Carol Gibb
New Zealand Institute of Medical Radiation Technology	Jo Anson
New Zealand Medical Association	Cameron McIver
New Zealand Medical Students Association	Cindy Towns
New Zealand Nurses Organisation	Eileen Brown
New Zealand Nurses Organisation – Midland	Wendy Thomas
New Zealand Overseas Doctors Association Incorporated	

Organisation	Name
New Zealand Register of Acupuncturists	Kevin Plaistead
New Zealand Society of Physiotherapists Inc.	Gail Leach
New Zealand Society of Podiatrists	Simon Speight
Northland District Health Board – Te Poutokomanawa/Mäori Directorate	Noel Mathews
Nurse Education in the Tertiary Sector	Jan Pearson
Nurse Executives of New Zealand	Rhondda Knox
Nursing Council of New Zealand	Marion Clark
NZ Federation of Vocational and Support Services	Tess Casey
Pathways and Blueprint Centre for Learning	Maree Maddock
Pharmaceutical Society of New Zealand	Joan Baas
Podiatrists Board	Trevor Tillotson
Psychologists Board – Workforce Committee	Andrew Symonds
Public Health Association of New Zealand	Fran McGrath
Royal Australian & New Zealand College of Obstetricians & Gynaecologists NZ Committee	Alastair Haslam
Royal New Zealand College of General Practitioners	Andrew Stenson
Royal New Zealand College of Surgeons	Phil Bagshaw
Royal New Zealand Foundation for the Blind	Paula Daye
Royal New Zealand Plunket Society	Angela Baldwin
SF Waikato (Supporting Families in Mental Illness) – Schizophrenia Fellowship	Jean Kneebone
Starship Children's Hospital	Scott MacFarlane
Taranaki Health – Health Promotion Unit	Heather Came
Te Rununga-O-Kirikiriroa	Sandra Eru
The Institute of Rural Health	Robin Steed
The New Zealand Association of Psychotherapists – Te Roopu Whakaora Hinengaro	Ms Rhona Carson
The New Zealand College of Clinical Psychologists	Barbara Chisholm
The Office of Disability Issues	
Tuwharetoa Health Services	Kamiria Gosman
Unitec – School of Health Science	
University of Auckland – Faculty of Medical and Health Services, Department of General Practice and Primary Health Care	Gregor Coster
University of Otago – Dietetic Training	Penny Field
Waikato District Health Board	Jan White
Waitemata District Health Board	Robin Youngson
Wellington People's Centre	Simon McLellan
Whitireia Community Polytechnic, School of Nursing and Health Studies	Jan Pearson

APPENDIX TWO – CONSULTATION MEETINGS

Date	Consultation	Venue
6 November	General/Fono	Alexander Park Raceway, Auckland
6 November	Hui	Freeman's Bay Community Centre, Auckland
12 November	General	Hamilton Gardens, Hamilton
20 November	General/Fono	Pataka, Porirua, Wellington
27 November	General	Christchurch Manufacturers Association, Christchurch
28 November	General	University of Otago, Dunedin
3 December	Hui	Te Papaiouru Marae, Rotorua
4 December	Hui	Rehua Marae, Christchurch

APPENDIX THREE – ATTENDEES AT THE MEETINGS

General, 6 November 2002, Alexander Park Raceway, Auckland

Name	Organisation
Adams, Des	Care Chemist Ltd
Alam, Dr Firoz	New Zealand Overseas Doctors Association
Anderson, Ronald	Ranfurly Vets Hospital
Astley, Pat	Seadrome
Blaiklock, Alison	Auckland District Heath Board – Public Health
Boyd, Hilary	NZ Foundation for the Blind
Carter, Taylor	New Zealand Nurses Organisation
Chivers, Tina	Seadrome
Disher, G	Royal Australasian College of Physicians
Faalili, Jacinta	Health Research Council
Fattah, Dr Sharif	New Zealand Overseas Doctors Association
Fernanda, Dr Indraka	New Zealand Overseas Doctors Association
Goodwin, Raewyn	NZ Life Care Ltd
Gribin, Maree	South Auckland Health
Harry, Lesley	New Zealand Nurses Organisation
Holland, Karen	Auckland District Health Board
Hoque, Dr Ekramar	New Zealand Overseas Doctors Association
Horsburgh, Margaret	University of Auckland
Jackman, Annette	Auckland District Health Board
Jansen, Sue	
Jayesdekar, Dr Ravidir	New Zealand Overseas Doctors Association
Johnson, Bev	Manukau Institute of Technology
Kinchin, John	Sunnynook Care Chemist
Leary, Rob	NZATU/NZASA
Leman, Jen	Elizabeth Knox Home and Hospital
Levack, Heather	Auckland District Health Board
MacFarlane, Scott	Auckland District Health Board – Starship
McGlynn, Sylvia	Elizabeth Knox
McKean, Bev	Auckland University of technology
Mueller, Janice	Auckland District Health Board
Ofanoa, Malakai	University of Auckland
Penlington, Debbie	Manukau Institute of Technology

Name	Organisation
Reason, Tracey	Cavit Rehabilitation
Reza, Dr Nasim	New Zealand Overseas Doctors association
Robertson, Ann	North Harbour Homecare
Rummel, Louise	Manukau Institute of Technology
Siddle, Paula	Presbyterian Support
Sorenson, Debbie	Counties Manukau District Health Board
Taufua, Ben	Counties Manukau District Health Board
Thornley, Lesley	Auckland District Heath Board
Walton, Jo Ann	Auckland University of Technology
Warmington, Noeline	Plunket
Webb, Tina	CCH and DS (public health nurse)
Whitehead, Noeline	Private Life Care (NZPHA)
Wright-St Clair, Valerie	Auckland University of Technology
Young, Susan	The Beachfront Resthome
Zhou, Ming	New Zealand Association of Traditional Chinese Medicine

Hui, 6 November 2002, Freeman's Bay Community Centre, Auckland

Name	Organisation
Cavit, Max	ABT Services Ltd
Kininmonth, Hugh	Te Korowai Hauora o Hauraki
Knutsen, Lorraine	Community Child Health and Disability Service
MacDonald, Kris	Auckland District Health Board and Hauora.com
Marsden, Lyvia	Te Puna Hauora
Paul, Pita	Auckland District Heath Board

General, 12 November 2002, Hamilton Gardens, Hamilton

Name	Organisation
Adlam, Kerri-Ann	Taranaki Health
Barnett, Chris	Waikato District Health Board
Brown, Carol	Waikato District Health Board
Clark, Rodger	New Zealand Institute of Medical Radiation Technology
Covell, Karen	Epilepsy NZ
Dixon-McIver, Dennis	APEX
Hallinan, Rob	APEX

Name	Organisation
Hunt, Charles	Taranaki Health
King, Rhondda	Matua Lifecare
Lawrence, Jane	WINTEC
Morris, David	New Zealand Institute of Medical Radiation Technology
Murphy, Barbara	Waikato District Health Board
Nel, Andre	Taranaki Health
Pettis, Jill [on behalf of Pauline Yates]	Hamilton Electorate Office
Pevreal, Diane	Waikato District Health Board
Roodt, Carli	Waikato District Health Board
Ross, Ruth	Waikato District Health Board
Scheepers, Etienne	Waikato District Health Board
Schinkel, Anna	Waikato District Health Board
Simon, Vicki	WINTEC
Spittal, Mark	Waikato District Health Board
Stewart, Kate	Waikato District Health Board
Welsh, Anne	Waikato District Health Board

General/Fono, 20 November 2002, Pataka, Porirua, Wellington

Name	Organisation
Acey, Frances	Disabled Persons Assembly
Aleni, Sia	Kemp Home and Hospital
Amoore, Anne	Midcentral Health
Anson, Jo	Midcentral Health
Areora, Chrissie	Kemp Home and Hospital
Ayling, John	Ambulance NZ
Bacou, Alofa	Kemp Home and Hospital
Blake, Marion	Platform
Boyd, Leonie	Council of Medical Colleges
Bratt, Dr David	Capital and Coast District Health Board
Brightwell, Cathy	Mental Health Commission
Bruce, Karen	Service and Food Workers' Union
Bulled, Debbie	Kemp Home and Hospital
Chapman, Chris	Kemp Home and Hospital
Copeland, Janet	New Zealand Society of Physiotherapists
Crombie, Anne	Practice Nurse
Davis, Helene	Te Puni Kokiri
Delaney, Lavinia	Kemp Home and Hospital

Name	Organisation
Dwyer, Julie	Occupational Therapy
Dwyer, Mike	Maraeroa Marae
Eagle, Yvonne	Kemp Home and Hospital
Eriepa, Margaret	Kemp Home and Hospital
Esserona, Alamoana	Kemp Home and Hospital
Gibson, Paul	New Zealand CCS
Hope, Sue	Healthcare NZ
Kiernan, Carol	Kemp Home and Hospital
Lauli, Losalia	Kemp Home and Hospital
Leslie, Peter	Council of Medical Colleges
Logorae, Fualaau	Hutt Valley District Health Board
Longworth, Anne	New Zealand Qualifications Authority
Maiawa, Ropata	Kemp Home and Hospital
Marshall, Kate	Capital and Coast District Health Board
McKinley, Sean	New Zealand Psychological Society
Mercer, Judy	Kemp Home and Hospital
Miti, Maria	Kemp Home and Hospital
Molloy, Siobhan	Capital and Coast District Health Board
Monigatti, Debbie	NZ Health and Hospital
Moore, Terry	Healthcare NZ
Muir, Georgina	State Services Commission
Neni, Sia	Kemp Home and Hospital
Newth, Sandra	Kemp Home and Hospital
Pihema, Christine	Hutt Valley District Health Board
Poasa, Tuli	Wellington Hospital
Puketapu, Kuini	Hutt Valley District Health Board
Skipper, Aana	Kemp Home and Hospital
Smith, Jenni	Live in Community
Stewart, Liffet	Whitireia Polytechnic
Taylor, Russell	New Zealand Nurses Organisation
Thompson, Joy	Kemp Home and Hospital
Thomson, Sarah	Diabetes NZ
Timu-Parata, Carmen	Mokopuna Solutions
Tiumalu, Diane	Kemp Home and Hospital
Togiafame, Rita	Kemp Home and Hospital
Turfrey, Gill	Hawkes Bay District Heath Board
Tuimatavai, Talila	Kemp Home and Hospital
Turia, Des	Whitireia Polytechnic

Name	Organisation
Vili, Oloa	Kemp Home and Hospital
Walker, Mary	Kemp Home and Hospital
Way, Colleen	Healthcare NZ, Hutt
Webber, Cathy	Royal New Zealand College of General Practitioners
Wongsee, Fiona	Kemp Home and Hospital
Wood, Karen	Royal College of Pathologists of Australia – New Zealand Committee

General, 27 November 2002, Christchurch Manufacturers Association, Christchurch

Name	Organisation
Andrew, Cathy	Christchurch Polytechnic
Brown, Adam	Canterbury District Health Board
Carnoutsos, Sue	Canterbury Health Laboratories
Cartwright, Jane	Canterbury District Health Board
Coburn, Craig	Canterbury District Health Board
Coe, Gill	Canterbury District Health Board
Coutts, Roz	New Zealand Public Service Association
Cromie, Brenda	Canterbury District Health Board
Davis, Vonny	Ignite
East, Sheree	Nurse Maude Association
Frost, Shelley	Pegasus Health
Gibling, Tony	Ministry of Health
Gill, Emily	New Zealand Medical students Association
Goode, David	Canterbury District Health Board
Gorman, Tony	New Zealand CCS
Hyland, Karen	Alzheimers
Kilburn, Judy	HealthCare NZ
Lamson, Suzy	Worksights
London, Martin	Centre for Rural Health
Marsden, Roger	New Zealand CCS
Marsh, Vicki	Community and Public Health
Milligan, Kaye	Christchurch Polytechnic
Milligan, Shirley	Canterbury District Health Board
Noseworthy, Susan	Canterbury District Health Board
Ozimek, Nick	Pegasus Health
Shield, Chris	Nurse Maude Association

Name	Organisation
Stanley, Nicky	Canterbury District Health Board
Storey, Siobhan	Canterbury District Health Board
Taylor, Kevin	Canterbury Health Laboratories
Ward, Shirley	Epilepsy Association
Willcox, Margaret	St Winifred's Hospital
Williams, Hector	Community and Public Health
Woodham, Felicity	Canterbury District Health Board

General, 28 November 2002, University of Otago, Dunedin

Name	Organisation
Chisholm, Barbara	NZ College of Clinical Psychologists
Coleman, Angela	Otago District Health Board
Cuff, Colleen	New Zealand CCS Otago
Dickson, Bridget	Isis Centre, Otago District Health Board
Gilbert, Eldred	Nursing Service Consultant
Grant, Krysia	Otago District Health Board
Hendry, Chris	Midwifery and Maternity Provider
Holmes, Ali	NZCCS Otago
Lowen, Barbara	Otago Polytechnic
McCall, Robyn	Healthcare NZ
McCreedie, Ros	Public Health South
McKewen, Shirley	Otago Polytechnic
Mellor, David	CADS Otago District Health Board
Murphy, Helen	Isis Centre, Otago District Health Board
Needham, Deborah	Isis Centre, Otago District Health Board
Pairman, Sally	Otago Polytechnic
Ramsay, Karen	NZ College of Clinical Psychologists
Roddick, Alan	Public Health South
Scheurenbrand, Petra	Otago District Health Board
Stewart, Sarah	Otago Polytechnic
Trusler, Bronwyn	Isis Centre, Otago District Health Board
Wilson, Margot	Sherwood Disability Trust

Hui, 3 December 2002, Te Papaiouru Marae, Rotorua

Name	Organisation
Andersen, Patrea	Waiariki Institute of Technology
Brown, Caron	Te Runanga o Aotearoa
Cooney, Cathy	Lakes District Health Board
Curd, Carlynne	Lakeland Health
Greeks, Vicki	Lakeland Health
Harawira, Hana	Te Kaokao o Takapau
Heke, Millie	Korowai Aroha
Jackson, Lois	Lakeland Health
Kirk, Shelley	Lakeland Health
Lambert, Sharon	Nga Ngaru Hauora o Aotearoa
Lane, Jane	Rotorua General Practice Group
Maraeroa, Chris	Ministry of Education Rotorua
Materoa, Naera	Koro Wai Aroha
McMillan, Sarah	Lakeland Health
Milne, Tania	New Zealand College of Midwives Bay of Plenty/Tairawhiti
Morreau, Johan	Lakes District Health Board
Navidad, Ana	LMC Rotorua
Osborne, Steve	Lakeland Health
Paul, Hakopai	Te Runanga o Ngati Pikaio
Pratt, Jocelyn	New Zealand Nurses Organisation
Rakei, Debbie	Tuwharetoa
Roy, Jenny	New Zealand Nurses Organisation
Smith, Carol	Lakes District Health Board
Tawa, Milton	Te Runanga o Aotearoa
Te Kowhai, Rock	Te Whänau Tokotokorangi Trust
Thomas, Witika	Te Whänau Tokotokorangi Trust
Wereta, Terry	Te Roopu Hauora o Te Arawa
Whata, Ngaire	Korowai Aroha
Williams, Mandy	Lakeland Health

Hui, 4 December 2002, Rehua Marae, Christchurch

Name	Organisation
Arahanga, Raku Lek Taiaroa	
Baker, Jane	Ignite
Croy, Cara	Ignite
Dallas-Katoa, Wendy	Mäori Health, Pegasus Health
Dewes, Dickie	Rata Te Awhina
Farrell, Marilyn	Cardiorespiratory Outreach/Canterbury District Health Board
Finlay, Annette	Mäori Clinical Development, Christchurch Hospital
Henry, Val	Rata Te Awhina
Huria, Tania	Pegasus Health
Johnston, Pip	IHC
Lawson, Gary	Ignite, Worksights
Peace, Dorothy	Ignite, Worksights
Peawini, Maraea	Cardiorespiratory Outreach/Canterbury District Health Board
Pimm, Fiona	He Oranga Pounamu
Pimm, Tatiana	Rehua Marae Nurse
Potiki, Tuari	Ngai Tahu Development/Canterbury District Health Board
Te Hae, Ted Mita	Community Public Health, Canterbury District Health Board
Win, Cecileah	Pegasus Health