

**Health Workforce
Advisory Committee**

Kōmiti Taunaki Kaimahi Hauora

Health Workforce Advisory Committee

Fourth Annual Report to the Minister of Health

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MANATŪ HAUORA

Foreword

This is the fourth annual report of the Health Workforce Advisory Committee (HWAC).

The report presents the work of HWAC in 2004 and also that of the Māori Health and Disability Workforce Sub-Committee and the Medical Reference Group. Both of these committees started their work programme in 2004 and are contributing towards our collective goal of helping to build a responsive and empowered health workforce for New Zealand.

The establishment of the Māori Health and Disability Workforce Sub-Committee in April represented an important development for the committee. The sub committee is made up of a group of people with considerable experience in Māori health. They have set about the important task of identifying key issues for Māori health workforce development. Their work this year has been around information gathering and facilitating collaboration between health and education providers. The first project under way is research on the economic benefits of increasing the number of Māori health professionals.

The committee's Medical Reference Group met for the first time at the beginning of 2004. Its initial work programme centred on the compilation of workforce information, analysis and informed opinion on relevant workforce issues. A consultation document will be distributed widely to the sector and analysis of feedback on this document will inform advice to the Minister in 2005.


HWAC is involved in a range of projects that support the implementation of recommendations made in our report – *The New Zealand Health Workforce Future Directions*, presented to the Minister of Health in 2003.

One of our key responsibilities is bringing together key players from within and outside of health to ensure a more collaborative approach is taken to investment in health workforce development. There is a wealth

of information within the health sector. Our challenge is to harness such information to contribute to the delivery of appropriate, quality services on as many fronts as possible.

Workforce development takes time and HWAC cannot do it alone. The committee appreciates the participation of the many people with an interest in workforce development who have contributed to committee deliberations by attending meetings or writing submissions in response to committee documents. During the year the committee met with a wide range of stakeholder organisations and values their contribution to our work.

The committee looks forward to contributing to the delivery of culturally appropriate, quality health services to improve health outcomes for all New Zealanders.



Prof Andrew Hornblow
Chair

Ms Taima Campbell

Mr Mike Gourley

Ms Karen Guilliland (Deputy Chair)

Ms Jane Lawless

Prof Colin Mantell

Dr Clive Ross

Dr George Salmond

Dr Margaret Southwick

Dr Ralph Wiles

Mr Ian Wilson

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Summary of the Committee's Work in 2004

Monitoring and evaluation

Purpose

To support monitoring of the implementation of workforce development recommendations made in *The New Zealand Health Workforce Future Directions – Recommendations to the Minister of Health 2003* to ensure recommendations are achieved within agreed timeframes, implemented to a high standard and contribute to achievement of the goals of the New Zealand Health Strategy and New Zealand Disability Strategy.

Workforce change must be carefully guided and nurtured to move from the present to a recommended health workforce capacity that utilises and builds on the current system's strengths and identifies barriers and possible resolutions. During 2004 the committee produced two background papers to assist with identifying its role in monitoring the implementation of recommendations made in *The New Zealand Health Workforce Future Directions – Recommendations to the Minister of Health 2003 (Future Directions)*. Guiding principles underpinning this work ensured the committee's contribution dovetailed with current accountability arrangements for the health and disability sector. A key principle underpinning this work ensured that the monitoring burden on the sector was not augmented rather supported to deliver on high quality workforce development objectives, in pursuit of achieving the goals of the New Zealand Health and Disability strategies.

The committee's role in this area involved guiding, facilitating and encouraging progressive change in moving towards our future health and disability workforce. In doing so, the committee played a key role in supporting the sector (often through the Ministry of Health to District Health Boards [DHBs], District Health Board New Zealand [DHBNZ] and

the primary health care sector) in providing guidance on monitoring its workforce achievements, whilst ensuring that the recommendations for workforce development were actively pursued. Many of the recommendations made in *Future Directions* have been carried out although some gaps remain. The challenge for the health and disability sector is to continue to work collaboratively to progressively implement all recommendations made in *Future Directions*. Working in these gap areas such as supporting the development of workforce development plans at DHB level, continuing to strengthen the interface between the health and education sectors, and fostering workforce development opportunities in the primary health care sector remains priority areas for the committee next year.

The greatest gain in workforce change is likely to occur in the primary health care area. Over time, the Committee plans to develop a small number of high-level national objectives for workforce development, against which achievement towards the recommended workforce balance can be tracked and evaluated.

Workforce innovation project

Purpose

To provide independent advice to the Minister of Health on innovative strategies to optimise the use of the health and disability workforce in order to achieve the goals of the New Zealand Health Strategy and the New Zealand Disability Strategy.

Future Directions signalled the need for new thinking about the roles and responsibilities of those involved in delivery of health and disability services. Changes to the way health practitioners are trained and deployed and to the way they work are crucial to achieve the desired outputs of the New Zealand Health Strategy and New Zealand Disability Strategy, given available resources and changing nature of the environment.

This year, the committee agreed to support a range of case studies on innovative workforce practices already occurring in the New Zealand health and disability sector. The studies were to focus on the lessons learned which then could be shared across the sector, with a view to informing new workforce developments. Case studies under way this year included the Lead Maternity Carer model in maternity care, innovative practices in the primary health care sector, and the introduction of the mental health community support worker role.

The report on a review of the development and introduction of the community support worker role in mental health is the first of a series of case studies the committee will circulate. Changes to health and disability services in recent times have reflected a welcome change to the set of values that underpin service delivery. New Zealand has moved from the outmoded belief that people should be 'cared for' in segregated institutions to the view that people ought to be supported to live well in the community. Nowhere is this shift in values more evident than in mental health.

Psychiatric hospitals have been progressively closed in favour of services delivered in community settings. As a consequence, the involvement of the non-governmental sector in providing support to people with mental illness in a variety of situations – from accommodation to employment – has been critical. That process has been well documented, both formally and informally. What is not so well documented or understood have been the dramatic changes to the nature and character of the workforce.

A review of the development and implementation of the mental health support worker role is timely. By improving understanding of an important initiative within one sector of disability support, namely mental health, the committee believes the sector will be better equipped to assist with the planning needs of the wider disability support workforce. The lessons learned from this review will help guide the sector in considering the role and status of the support workforce across the health and disability sector. In HWAC's document *Framing Future Directions* the committee furthered discussions around these themes, and

as a result (as part of formulating a number of recommendations to the Minister) it intends to initiate strategic discussions around support workforce issues early next year.

A second case study under way by the committee in 2004 was a review of the lessons learned from the development and introduction of the Lead Maternity Carer model in maternity care. Prior to 1970 midwives provided maternity care without doctor's involvement. The Nurses Amendment Act 1971 changed this by requiring all births to be supervised by a doctor. As the consumer voice strengthened in the community in the 1980s, midwives became an effective lobby group, along with support from national organisations. In the Nurses Amendment Act 1990 midwives were permitted to practice as independent providers of pregnancy and childbirth services without reference to or supervision of medical practitioners. Accompanying changes enabled midwives to prescribe, order laboratory tests and claim maternity benefit payments at the same rate as doctors.

The committee believes that the LMC model is a good example of innovative workforce practice in many respects. The context encompassing the change process in maternity care in New Zealand yields many lessons of what could have been done differently if we were to embark on a similar process elsewhere in the health sector. It contributes to learnings related to supporting positive workforce change. The LMC aspect of maternity care is regarded by many; locally and internationally, as an innovative and brave undertaking embarked upon in the New Zealand health system. Issues regarding consumer choice, patient-centred care, recognition of full scopes of practice for midwives, improved standards and health outcomes, along with professional boundaries, education/training requirements, recruitment and retention implications are explored in this case study report. The report will be published in 2005 following consultation on its findings.

Other examples of innovative workforce practice in the primary health care area (see primary health) have been written up this year. These case studies along with the community support worker role in mental health

and the LMC model in maternity care will inform a set of guiding principles for supporting positive workforce change. Development of the principles will be a priority for the committee next year.

The key findings from this work will inform advice to the Minister of Health on how to support new and innovative ways of working in the health system. As international labour shortages emerge and future demand for health services are forecast to rise rapidly over the next 20 years, the committee sees work in this area as being vital for the sector. Attention must shift to how the health and disability service labour supply can be better educated, trained, developed, deployed and retained.

Healthy workplace environment guidelines

Purpose

The purpose of the Healthy Workplace Environments Guidelines project is to develop, in consultation with the Ministry of Health, DHBNZ, and professional bodies, a set of national guidelines for implementation and monitoring of healthy workplace environments by June 2005, as recommended in *Future Directions*.

The healthy workplace environments guidelines will promote a range of practices healthy workplace environments in health care organisations to address retention and recruitment issues, improve workforce diversity, and ensure improved health outcomes. The project was based around promoting healthy hospital environments, as discussed in HWAC's 2002 *Framing Future Directions* discussion document outlining the six guiding principles for a healthy workplace.

The Guidelines will seek to support improvement in:

- retention and recruitment of the New Zealand health workforce across the health sector and all health disciplines
- organisational performance and sustainability

- workforce diversity to more accurately reflect the demographic makeup of New Zealand
- the quality of work life for all health practitioners in all settings.

Three background papers have been completed this year, with a further three papers under way. The first of three papers completed this year looked at high performing organisations (addressing organisational performance). The paper described the attributes of high performing organisations and found:

- high performing organisations place the workforce at the centre of their organisations and enable discretion and autonomy in the workforce
- high performing organisations view quality improvement as often the best way to reduce costs
- high performing organisations must introduce high performance practices in bundles and that the bundles must align with the organisation's strategic direction and internal human resources practices to be effective.

The second background paper completed this year explored the implications of the changing structure of the health workforce. The paper found that:

- the New Zealand health workforce is ageing, becoming more ethnically diverse and increasingly feminised
- retaining an ageing workforce longer will be crucial as there will be fewer younger people entering the workforce in the future
- increasing feminisation of the workforce has implications as female practitioners tend to work fewer hours, work part time, and are more likely to take career breaks than males
- increasing ethnic diversity may require strategies to make a health career more attractive to Māori and Pacific peoples and improve their representation in the health workforce

- changing work patterns affect both genders as both males and females seek flexible employment arrangements to enable a work/non-work balance
- leadership will have a central role in changing organisational culture.

Leadership can positively support healthy workplace environments and the improvement in retention and recruitment of a well-trained health workforce. Leadership was the topic of the third background paper completed for the committee this year. This paper noted that:

- leaders are required at all levels on organisations if they are to change or adapt to the external environment
- the characteristics of effective managers are similar to those of transformational leaders. The most obvious is that leaders focus on the their people rather than the tasks they perform
- the workplace can be structured and organised such that it can nurture leaders and leadership
- clinicians need to be encouraged into leadership roles possibly through clinical governance
- improving retention and recruitment will benefit from interventions largely under the umbrella of human resource management
- the relationship between leadership (as describes and discussed in the paper) and retention and recruitment is tenuous. However, there is enormous potential for leadership to positively support healthy workplace environments.

The medico-legal environment, workforce interactions and leadership from a human resources perspective are the broad topics of the three papers currently under way. Early next year, the committee expects to consolidate the background papers to help inform the development of a set of final guidelines. A wider sector group comprising key stakeholders will be established to discuss the key themes and draft guidelines. A final set of healthy workplace guidelines will be promulgated in late 2005.

Primary health care workforce initiatives

Purpose

To build up the knowledge base of innovative primary health care workforce practices being implemented within District Health Boards (DHBs).

The committee's work in this area has included two projects under way in 2004. The projects were:

- innovative primary health care workforce initiatives project
- an initial database of DHB primary health care workforce development initiatives project.

Innovative primary health care workforce initiatives project

This year the committee commissioned the innovative workforce initiatives project to gain a better understanding of the characteristics and processes for trustworthy change management and new paradigms for service delivery in primary health care. The project comprised of four case studies, covering two broad areas of primary health care workforce development:

- developmental processes and the ways in which the environment for innovation came about
- innovative practice initiatives under way, and focusing on doing things differently, by different people, in different environments.

The project focused on primary health care providers, with secondary views obtained from DHBs. Each of the case studies provided a contextual description of the delivery of primary health care and the Primary Health Care Strategy. The case studies explored the drivers behind the formation of the organisational structures delivering primary health care within a DHB's boundaries, eg, intersectoral collaboration, and the appropriateness of organisational structures to both their communities and to the range of health practitioners involved in primary health care service delivery.

A draft report has been released to the committee. The committee will consider a final report next year in light of further work proposed in this area. Some of the findings drawn from the draft report included the following.

Primary health care configuration

- DHBs have worked for the past 12–18 months to establish Primary Health Organisations (PHOs). PHOs were the key drivers for implementing and delivering the Primary Health Care Strategy.
- There were different drivers for the formation of PHOs. Some PHOs had evolved from existing provider teams, especially in rural and high needs areas, while others had previously been Independent Practice Associations who became a PHO or part of a PHO structure.
- The relationship between DHBs and PHOs were found to be supportive. Support was attributed to transparent communication.
- The Primary Health Care Strategy provided direction and resources to create structures for teams and teamwork. PHO boards provided leadership, and leaders were also visible in the management teams/ personnel and advisory committees found within the structures.
- Services to increase access, and health promotion plans projects were viewed as providing the opportunity for multi-disciplinary teams to gain experience of working together in different ways across different providers.

Workforce innovation

- The Care Plus, Services to Increase Access, and Health Promotion Plans had precipitated most workforce innovations. Other new initiatives were in the early stage of development.
- Change management was found to be a process of facilitation that brought providers together to identify what each had to offer, find gaps and ways in which they can work together.

Education and up-skilling the existing workforce

- Some DHBs saw their role up-skilling and professional development as providing resources to PHOs; others were more actively facilitating workforce training. PHOs also differed in the extent to which they were able and/or were involved in up-skilling the workforce. Some provide training to their members, while others devolved training to the providers themselves.

Teams and teamwork

- Multi-disciplinary teams and intersectoral collaboration were required for the delivery of population-based health. Teamwork was at varying stages of development. Teamwork was not new in some areas: 'not for profit' organisations were commonly cited as more likely to be effectively using multi-disciplinary teams.

Recruitment issues

- Primary health care recruitment was viewed as constraining workforce development. Primary health care was not seen as an attractive option for most practitioners and, as a result, was not attracting new staff and/or new graduates.

Database of DHB primary health care workforce development initiatives project

This project set out to establish a baseline data on primary health care workforce development activities across DHBs by analysing selected District Annual Plans (DAP) for 2004/2005 and other strategic documents for alignments to primary health objectives.

The project was undertaken as part of the committee's monitoring and evaluation work stream. A review of the selected DAPs was completed as a background paper that assessed how health workforce development progress was being planned and aligned with *Future Directions*.

Māori Health and Disability Workforce Sub-Committee

The Māori Health and Disability Workforce Sub-Committee was established in March 2004. The committee identified a need for a national Māori health and disability workforce strategy through its *Framing Future Directions* discussion document and subsequent consultation. The Māori Sub-Committee is tasked with the role of providing independent advice on Māori health and disability workforce development issues to the Minister of Health. The first meeting of the sub-committee was held in April 2004 with three subsequent meetings held since.

The members of the Māori Sub-Committee are:

Professor Colin Mantell (Chair) (HWAC)

Taima Campbell (Deputy Chair) (HWAC)

Dr Paratene Ngata

Lynette Stewart

Hayden Wano

Fiona Pimm.

The Māori Sub-Committee has produced a work plan for 2004–5 based on the key tasks in their Terms of Reference.

The first key task is to provide advice on Māori health and disability development issues.

To begin to address this the Māori Sub-Committee has:

- Commissioned a research project to investigate the economic impact of increasing the number of Māori health professionals in New Zealand. The sub-committee believes significant economic benefits could be gained for New Zealand from increases in the numbers and proportion of Māori health professionals. Increases in the Māori health workforce will also lead to improvements in Māori health

through a number of mechanisms. A report will be released detailing the outcomes of this project.

- Commenced work on reports that will present information on:
 - current numbers of Māori in the regulated health workforce
 - current numbers of Māori training in tertiary courses for health occupation
 - Māori student participation and achievement in secondary school science. The sub-committee believes lack of achievement in science at secondary level is a key factor influencing the available pool for tertiary health courses.
- Commenced work on a discussion document that summarises key issues for Māori health workforce development. Submissions will be sought from the health and education sectors.

The second key task is to facilitate collaboration between health and education providers on workforce development. To advance this, the Māori Sub-Committee has established relationships with the Ministry of Education, the Tertiary Education Commission and DHBNZ.

Three specific initiatives under way this year included the following.

- Meeting with representatives from the Ministry of Education to look at disparities between Māori and non-Māori for participation and achievement in science at secondary school. The sub-committee believes policy and interventions are required to address these disparities as not only is the selection of science at secondary level a prerequisite for entry to tertiary health courses but also these courses require high levels of secondary science achievement. The Māori Sub-Committee believe action that intervenes at secondary school level is required.
- Collaborating with the Royal Society of New Zealand to host a joint symposium on science education issues for Māori and Pacific peoples in New Zealand in March 2005. This workshop intends to gather experts from the research, education and health sectors to develop

policy solutions for increasing participation and achievement of Māori and Pacific students in secondary school science. The policy options developed at this symposium will form part of a discussion document.

- Meeting with representatives from Te Wānanga o Aotearoa one of the Māori universities. Te Wānanga o Aotearoa has a Māori-centred approach to life-long learning and its accompanying knowledge base, pedagogy and research programmes. The sub-committee plans to discuss options for Māori students wishing to pursue health careers through second chance education. The sub-committee would like to see the establishment of health foundation courses for second chance learners at the Wānanga. Links could then be made between the Wānanga and existing tertiary health course institutions as a means to progress successful foundation students through to these tertiary health courses.

The third and fourth tasks centre on monitoring other organisations in their delivery of Māori health and disability workforce development and monitoring and evaluating the implementation of HWAC's recommendations to the Minister of Health in relation to progressing Māori health and disability workforce development. The Sub-Committee expects to progress this work next year.

Medical Reference Group

The Minister of Health approved the establishment of a Medical Reference Group in November 2003 to provide independent advice to HWAC and to work within HWAC's Terms of Reference. The Medical Reference Group was established to address medical workforce issues and initially tasked with:

- assessing medical workforce information requirements for supply and demand analysis, taking into account:
 - demand for doctors, including how they deliver services and medical workforce capacity requirements

- current supply from the education sector and immigration, also recruitment and retention issues
- planning processes, to improve information systems and use of short- and long-term measures to ensure capacity
- professional issues including professional development, flexible employment opportunities, career pathways and so on.
- reviewing the structure of medical service delivery. This project will explore doctors work in terms of specialist, generalist and resident medical officer roles in an environment of patient-centred service delivery. Primary care, cancer control and diabetes may be used as examples to explore this issue.

The members of the committee are:

Dr George Salmond (HWAC) – Chair

Professor John Campbell

Dr Peter Leslie

Mrs Anne Kolbe

Dr Don Simmers

Dr Dwayne Crombie

Dr David Galler

Ms Cindy Towns

Dr Ralph Wiles (HWAC)

Ms Jane Lawless (HWAC)

The Medical Reference Group held its first meeting on 30 January 2004 and has met on six occasions.

The initial work programme centres around the compilation of workforce information, analysis and informed opinion on relevant workforce issues, into a consultation document for distribution to the sector. This consultation document will bring together up-to-date information on the characteristics of the medical workforce together with analysis of future

pressures and opportunities for that workforce. The consultation document will acknowledge the important changes facing the workforce due to demographic change, increased expectations of patients and new working practices.

The consultation document will seek submissions from interested parties. Analysis of submissions providing feedback on this document will inform advice to the Minister in 2005.

In addition the committee has commissioned a report analysing general practitioner availability and utilisation. It is hoped that this report will inform the work programme of both the Medical Reference Group and HWAC during 2005.

Other committee work

This year the committee consolidated its work around its key project areas, guiding the implementation of its recommendations to the Minister of Health on workforce development and establishing work programmes for each of its sub-groups. Areas of ongoing interest for the committee in 2005/2006 will be on continuing to facilitate the development of the health and education interface, nursing and allied health workforces, the Pacific health workforce and disability.

The committee continued to work with a wide range of stakeholder organisations throughout the year via its committee meetings, speaking engagements and by invitation. As an example, some of the conference highlights for two of its committee members for this year included:

Prof. Andrew Hornblow

3rd Health Education Interface Workshop, Wellington

Crown Entity Chairs Meeting, Wellington

RNZMA/NZIHM Conference, Rotorua

HPCA Launch – Wellington

Dr George Salmond

RNZCGP Leadership and Learning Workshop

Magnet New Zealand Conference, Wellington

IPAC New Zealand Conference, Rotorua.

3rd Health Education Interface Workshop, Wellington

Health Innovations Awards, Wellington.

Public Health Association Conference, Christchurch

RNZCGP Health Services Research Forum, Wellington.

RNZCGP Conference, Wellington

The committee maintains a close working relationship with the Ministry of Health and DHBNZ to ensure a coordinated approach to workforce development. During the year, the committee (either through its secretariat or two sub-groups) has also worked with other government departments such as the Ministry of Education and Tertiary Education Commission, a range of registration authorities, vocational colleges, professional associations and other organisations to further advance health workforce issues, to better meet the health needs of the New Zealand population.

Health Workforce Advisory Committee

Terms of Reference

Objectives

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

The advice given by the committee to the Minister is to be formulated after consultation with people involved in the funding and provision of services and any other people that the committee considers appropriate.

The committee will report its advice to the Minister of Health.

Accountability

The committee is established by and accountable to the Minister of Health.

Key tasks

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

- 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 Strategy and the New Zealand Disability Strategy
- advise the Minister on national goals for the health workforce and recommend strategies to develop an appropriate workforce capacity

- facilitate co-operation between organisations involved in health workforce education and training to ensure a strategic approach to health workforce supply, demand and development
- report progress on the effectiveness of recommended strategies and identify required changes.

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

In developing its advice, the committee may consider:

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

Health Workforce Advisory Committee

Members



Professor Andrew Hornblow, CNZM (Chair)

Professor Hornblow is a psychologist, and is a former Dean of the Christchurch School of Medicine and Health Sciences, University of Otago. He is currently also Chair of the Alcohol Advisory Council. He has served on the Health Research Council and the Public Health Commission, was Foundation President of the New Zealand Public Health Association, is a former Chairman of the

Mental Health Foundation, and a past President of the New Zealand Psychological Society.

Ms Karen Guilliland, MNZM (Deputy Chair)

Karen Guilliland is a midwife and is currently the CEO of the New Zealand College of Midwives. She is a Board member of PHARMAC, a member of the Canterbury District Health Board, and a member of the Minister of Health's Health Advisory Group. She is a former member of the Canterbury Area Health Board and the New Zealand Nursing Council.



Dr Ralph Wiles

Ralph Wiles is a general practitioner practising in Tokoroa. The practice has a high number of Māori and Pacific patients. Ralph held the position of Chairperson of the Royal New Zealand College of General Practitioners from 1997 to 2001.



Dr Clive Ross, CNZM

Clive Ross is a dental practitioner in Auckland, and is also a registered as a specialist in restorative dentistry. Clive actively participates in the World Dental Federation, which represents dental associations and individual dentists worldwide. He is also a member of the World Health Expert Advisory Committee, and he chaired the joint WHO/World Dental Federation study on workforce methodology. He is a past Chairman of the Dental Council of New Zealand.

Professor Colin Mantell

Colin Mantell is Professor of Māori and Pacific Health and Head of the Māori and Pacific health Department of the University of Auckland. He is a Professor of Obstetrics and Gynaecology at National Women's Hospital and has held head of department posts at National Women's Hospital and Middlemore Hospital in South Auckland. Colin is a past member of the Health Research Council of New Zealand and a member of the Māori Health Research Committee. Colin's iwi affiliation is Ngai Tahu.



Mr Mike Gourley

Mike Gourley has been self employed since 1995 working on contract to National Radio and Long White Cloud Productions. He has been employed by the Wellington College of Education as a lecturer in Disability Studies, and is a member of the New Zealand Disability Strategy Sector Reference Group.



Dr George Salmond, Chair, Medical Reference Group

George Salmond is a public health consultant, with extensive involvement in research and policy on health workforce and health services over many years. He was Director-General of Health from 1986 to 1991 and has held various other senior health appointments, nationally and internationally.

Ms Jane Lawless

Jane Lawless is a staff nurse at Waikato Hospital, and Chairperson of the College of Emergency Nurses New Zealand (New Zealand Nurses Organisation).



Dr Margaret Southwick

Margaret Southwick is the Head of School, Pacific health Research Centre, Whitireia Community Polytechnic. She is also a member of the nursing Council of New Zealand and a peer review panel member of the health panel for the Performance-based Research Fund.



Mr Ian Wilson

Ian Wilson is an experienced Company Director and is the Chair of MidCentral District Health Board and the institute of Environmental Sciences and Research Limited. He is also a Director of a number of other private and public companies.

Ms Taima Campbell

Taima is Executive Director of Nursing and Midwifery, Auckland District Health Board. As a registered nurse she brings extensive experience in child health and community care. She is also Clinical Director for hauora.com, a National Māori Health Workforce Development Organisation and a board member of Te Rau Matatini, a Māori Mental Health Workforce Development Organisation, a member of Magnet New Zealand, and the College of Nurses Aotearoa. Taima's iwi affiliation is Ngāti Tamaterā, Ngāti Maru.



Secretariat information

Alison Hannah – Team Leader (until June 2004)

Kanita Nikora – Senior Analyst and Acting Team Leader (July – September 2004)

Liz Stephenson – Senior Analyst

Frances Townsend – Senior Analyst

Nicholas Kildare – Analyst

Sheryl Hall – Executive Assistant

Mark Booth – Acting Team Leader (September 2004 onwards)

Irene Braithwaite – Analyst (November 2003 – February 2004, November 2004 – February 2005)

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This report and all other Health Workforce Advisory Committee publications are available on the committee's website

<http://www.hwac.govt.nz>