

Annual Report to the Minister of Health January 2022

Health Workforce Advisory Board

Introduction from the Board Chairperson

"The pandemic has taken us to the abyss. What have we learned? How do we change our ways?" Bruno Macães.

This is the second Annual Report to the Minister of Health from the Health Workforce Advisory Board (HWAB) which was introduced in 2019 under section 11 of the New Zealand Public Health and Disability Act 2000.

The Board was established to provide advice to the Minister on health workforce matters including strategic direction, emerging issues and risks. Under s15 of the Act, the Board must report to the Minister at least once a year in relation to its statutory purpose. A copy of the report will be presented to the House of Representatives by the Minister.

Its work in the past year has been dominated by the global pandemic, COVID-19, and the health reforms which will see District Health Boards dis-established by 30 June 2022 and new centralised structures, Health New Zealand, and the Māori Health Authority, take over the delivery of health services to Aotearoa New Zealand.

Transitional change has impacted on the composition of both the Board and the Ministry of Health's Health Workforce Directorate during 2021. The Board lost a number of members to take up positions in the Ministry, while two of them continued to act in an advisory capacity and HWAB benefitted from their collaboration. The ex-officio Board member representing DHBs was often unavailable due to COVID-19 demands in the Northern region and one Board member was working in Samoa for much of the year. The Ministry, in turn, lost

several senior managers in the workforce directorate over a short period of time.

Three new Ministerial appointments were made to HWAB at the end of 2021, to supplement membership going forward and the Board looks forward to their contribution to its work.

The Board works with the Ministry of Health, in particular alongside the Health Workforce Directorate. It has no personnel, funding or budget management responsibility and is concerned with the whole of the health workforce, both regulated and unregulated. The Board's Terms of Reference include providing strategic oversight, advice and recommendations on matters relating to health workforce including but not limited to:

- (a) Planning for New Zealand's health and disability system workforce
- (b) Enabling greater participation of Māori in the health workforce and partnering with Māori to better understand the needs and aspirations of the Māori workforce
- (c) Enabling greater participation of Pacific and other under-represented populations in the health workforce
- (d) Education, training and development of the health workforce
- (e) Health workforce wellbeing
- (f) Supporting quality improvement, innovation and changed ways of working.

These will be referred to in the following report.



Dr Judy McGregor

Chair, Health Workforce Advisory Board

Board scope in 2020/2021

The limited composition of HWAB and management change within the Directorate throughout the past year was a challenge, mitigated by strong cooperation between the Board and the Ministry. Both Lorraine Hetaraka and Dr Andrew Connolly continued to provide HWAB with support and advice even after they had taken up high level Ministry positions. Two members, Dr Karl Metzler and Professor Jo Baxter provided welcome and conscientious continuity and high-level advice.

Advice and support to the Directorate was provided on the following activities:

- (a) Interface of education and health (including advising the Minister of Health to create a joint body comprising Ministry of Health, Ministry of Education/Tertiary Education Commission to work collaboratively on health workforce matters; and advised officials on the development of a joint education and health work programme)
- (b) Regulatory reform
- (c) Leadership development programme (including sharing insights on the benefits of digital preparedness, health science academies and clinical digital academy)
- (d) Internal review of the Health Workforce Directorate contracting process / DHB funding and prioritisation framework
- (e) Vaccinator surge workforce and the COVID-19 vaccinator role
- (f) Data collection on the non-regulated workforce

- (g) Māori Health Workforce Action Plan and Pacific Health Workforce Action Plan (including advising the Associate Minister of Health (Pacific peoples) on the low Pasifika representation in the health sector)
- (h) Health system reform programme (including engaging with the Transition Unit on the Health Charter and the New Zealand Health Plan).

During the year, the Board engaged with various stakeholders on a range of matters including:

- Professor Margaret Wilson, Deputy Commissioner; Kate Coley, Executive Director for Organisational Support; and Riki Nia Nia, Executive Director for Māori Equity and Health Improvement, from the Waikato District Health Board
- Professor Sarah Strasser, Dean; and Professor Roger Strasser, from Te Huataki Waiora School of Health, University of Waikato
- Jill Ovens and Caroline Conroy, co-Chairs of the Midwifery Accord
- Stephen McKernan; Andrew Norton; and Dr David Galler from the Transition Unit
- Fiona McCarthy, Chair; and Brenda Hall, Workstream Lead, from Kahui Oranga Wellbeing for Health Programme
- Margaret Dotchin; Allison Plumridge; and Rebecca Kay, from the Nursing Pre-registration Pipeline Project
- Professor Peter Crampton from Kōhatu, Centre for Hauora Māori, University of Otago.

COVID-19 and health workforce issues

The defining health workforce concern for Aotearoa New Zealand, as it is internationally, is health sector responsiveness to the continuing waves of COVID-19 infections. The global pandemic and new variants of COVID-19 will dominate the health services and delivery landscape in the short and medium term, with predictions of a five to 10-year horizon.ⁱ The health workforce is the critical determinant in successful responses to vaccination campaigns, to surge demand in hospital and community settings, and to prevention campaigns and containment of existing and new variants. So far in response to the pandemic the health workforce has been “scaled up, redeployed, repurposed, retrained and retained”.ⁱⁱ

The health workforce in Aotearoa New Zealand has been critical to the successful 90% plus vaccination achievement, to the health care of COVID-19 infected patients in hospitals and in home isolation, to the effectiveness of the contact tracing and testing regimes and to the public health initiatives prompted by the pandemic. But the rolling patterns of COVID-19 variants has placed the workforce under unimaginable pressures.

The degree to which the health workforce can sustain the demand waves of the virus will depend on how well the system can adapt to the collaborative learning unleashed by COVID-19, and to the higher degrees of flexibility and improvisation required to achieve problem-solving under pressure. Leadership is vital.

Several critical workforce issues are impacting on health care services during

COVID-19 and post the pandemic. The most immediate is labour force availability. There are widening gaps in critical areas at a time when COVID-19 related immigration constraints inhibit the usual practice of attracting international medical and health care workers. Secondly, and no less important, is health workforce wellbeing including burnout encompassing physical, mental and emotional exhaustion and stress plus the immediate and long-term effects of COVID-19 on the health workforce.

Both- labour force availability and health workforce wellbeing- highlight the critical need for focussed health workforce retention strategies, and a targeted and purposeful approach to the retention and development of new health workforces in the kaimanaaki and peer, lived experience spaces. These tactical initiatives should be prioritised and would complement the continuing focus on health workforce recruitment.

Workforce governance issues

COVID-19 has graphically exposed the limitations of traditional health workforce governance and signals the need for a radically different approach with the identification of the agency who has the “power to act”. In many countries, pandemic responses have broken up “sclerotic governance structures” which have hampered past health workforce development and reform.ⁱⁱⁱ

Complexity of the health workforce ecosystem and time-worn patterns mark the traditional slowness of health workforce

development and reveal that there is no quick fix. A number of autonomous stakeholders with vested interests working in silos hampered by a lack of streamlined and authoritative coordination has resulted in often inflexible health workforce governance.

Several agencies and organisations have different roles and accountabilities in the education, training and regulation of the health workforce. The policy drivers of education providers are often not in alignment with the needs of the health sector and coherent, holistic workforce development. Operating in a commercial and often competitive environment, education providers can exit from health programmes, change the lengths of programmes and their delivery models and elevate or downgrade the level of a programme, without recourse to health sector demand and supply influences.

There are at least a dozen health professions trained at undergraduate level and funded by the Tertiary Education Commission with overall policy responsibility sitting with the Ministry of Education, which are at risk of not meeting health workforce demands. These include registered nurses, the vanguard of pandemic responsiveness, registered midwives, those working in drug and alcohol addictions, psychotherapists, medical laboratory and anaesthetic technicians, medical laboratory scientists and pharmacists.

Many of the shortages are endemic. For example, at a time of a continuing critical lack of midwives, the total number of new enrolments in 2020 was 239, 18% lower than the 2010 figure of 292, and annual completion figures for pre-registration

was a low 139. However, the health sector has no influence on the level of support offered by education providers to ensure those students that the providers admitted to their programmes, actually stay the course and graduate, thereby realising an adequate return on public funding and individual student investment in midwifery education.

In its six-monthly report to the Minister in July 2021 HWAB recommended the formation of a joint health-education mechanism. This was followed by a letter from DHB Chairs and CEOs. Following communication between ministers, the Ministry's Health Workforce Directorate began working with officials at the Ministry of Education and the Tertiary Education Commission to establish a mechanism to ensure health workforce sustainability.

The impetus afforded by COVID-19 to better coordinate the four strands of workforce governance (government departments and ministries; professional councils and employee associations; universities; and politicians/legislators) to provide purposeful, speedier and pragmatic decision-making informed by clinical safety, should not be lost. But it requires an urgent, focussed approach with an identified single agency with a "power to act".

The Health and Disability System Review recommended that *"the Ministry should work with the Tertiary Education Commission, Health NZ, the new New Zealand Institute of Skills and Technology (NZIST) and other regulatory authorities and training establishments to ensure all relevant training is consistent with the goals of the NZ Health Plan and*

accompanying strategies.” However, in addition to collaboration, a mandated decision-maker is required for purposeful change. Addressing workforce shortages and workforce planning involves all health entities and both the Māori Health Authority and Health New Zealand will have new levers to combat shortages and plan coherently across the system.

For example, currently approximately \$110 million is annually allocated to DHBs for medical training. This has resulted in some lost opportunities for training in rarer sub-specialties because of the disconnection between funding and where training can occur. Neuro-interventional radiology for clot retrieval is an example.

The multiplicity of autonomous decision-makers with different accountabilities characterises the current health workforce eco-system, to its detriment. Health New Zealand and the Māori Health Authority have a unique opportunity to break business-as-usual patterns for the benefit of patients and whānau.

Health New Zealand, as a single employer replacing 20 DHB employers, is a catalyst for implementing radically changed health workforce development in line with the New Zealand Health Plan. Additionally, it is critical that the Ministry of Health be a mandated policy decision-maker with the power to address and align settings across education, health and the professional associations to ensure a sustainable health workforce.

The Board fully supports the Ministry’s review of health professional regulatory settings including the Health Practitioners

Competence Assurance Act 2003, with a target deadline of draft legislation by November 2022. This is part of a whole of system approach to health workforce development. Responsible Authorities accredit and monitor health education programmes that lead to registration under the Health Practitioners Competence Assurance Act 2003. The Board continues to be concerned that the 17 Responsible Authorities responsible for 24 regulated professions have full autonomy in setting accreditation standards, but without the consequent responsibility for policy settings relating to accreditation standards, which are required for a responsive, pressured and changing health sector. In addition, it is timely to review College functions. For example, a College needs to have a selection process for entry to training but the success or otherwise of such a process, including its effectiveness in addressing equity representation of Māori and Pacific and the need for a rural workforce, is not relevant.

HWAB recommends to the Minister that the regulatory review and other work to advance more flexible regulatory settings be prioritised during the transition period as part of new health workforce governance frameworks.

Vaccinator workforce

A positive example of COVID-19 health workforce disruption is the development of vaccinator assistants to relieve reliance on registered nurses during the vaccination campaigns of 2021. This was a Ministry initiative strongly supported by HWAB and DHBs. Changes of scopes of

practice (with supervision) which have previously been resisted and new competency and training programmes were rapidly developed for online delivery in response to the pandemic. More than 300 have been trained, 50 are fully authorised and working in the field and 50% of those who trained are Māori.^{iv} Long term opportunities to build an auxiliary workforce and retain this new skill set exist for continuing pandemic responsiveness to booster shots and to vaccinating younger New Zealanders in 2022. In the future, vaccinator assistants as an auxiliary workforce can have a legacy effect in vaccination by helping to address New Zealand's worrying fall in childhood immunisation statistics particularly among Māori and Pacific peoples. This has been identified as a priority activity for regional health governance during the transition period.

HWAB recommends to the Minister that supporting, retaining and increasing the vaccinator assistant workforce and improving its professionalisation to allow a legitimate scope of practice, be a regional workforce priority.

Student placement

COVID-19 considerably disrupted student clinical placements during 2021, resulting in some delays to registration for physiotherapy, dental, occupational therapy, other allied health jobs and medical students. For example, approximately 100 physiotherapy students are normally allocated annually to Waitematā, Auckland and Counties Manukau and Northland hospitals, working in cardio vascular and cardio

respiratory and other wards. However, they had no access during outbreaks in the Northern region under Alert Level 4 on the legitimate basis of student safety and because of prioritised demands on supervisory staff during pandemic responses. Similarly, dental students based in Auckland could not graduate in December 2021 due to the lack of clinical hours. Professional registration requires fixed numbers of clinical hours for different workforces.

Now the health sector has learnt more about hospital management and COVID-19, and in response to the urgent need for new graduates.

HWAB recommends to the Minister that national policy allows continuation of student hospital placements during pandemics such as COVID-19 unless there are exceptional demands on hospital wards and services that should curtail placements.

Educational institutions plus placement facilities should be responsible for ensuring adequate mask fitting and safety education. Two for one supervisory ratios introduced by some DHBs during COVID-19 have helped reduce demand on hospital staff in these roles and need not necessarily impact on the quality of student placement.

Health workforce wellbeing

New Zealand's favourable position amongst OECD countries in combatting COVID-19 has come at a price. The pandemic has placed considerable

pressure in New Zealand and elsewhere on health workforce availability, retention and health care worker wellbeing.

As a positive, the pandemic provides dozens of health workers with new and challenging professional experiences in pandemic leadership, in incident management, in vaccination and testing work away from routine ward shifts, in epidemiology, in laboratory testing and in a variety of public health contexts.

COVID-19 also made highly visible the agility and efficiency of Māori and Pacific providers and community-based NGOs working with vulnerable communities to respond in culturally safe ways to community transmission and the vaccination programme. The pandemic also catalysed new forms of health sector delivery in which bureaucratic processes were secondary to digital health services.

There are, though, many thousands of health workers (especially in regions where COVID-19 has predominated) at the front line in emergency departments, in COVID-19 wards and roles, and in community settings, who feel emotionally, physically and mentally exhausted. Some health workers also feel under-valued and are complaining of a loss of moral authority and personal work satisfaction as they are redeployed in COVID-facing roles which may not see them working at the top of their scope of practice.^v

Health care professionals, in aged care, hospital and community settings have faced the fear and risks of infection for themselves, family and whānau. Several thousand health care assistants, security guards, cleaners, nurses and doctors, have faced anxious stand-down periods often in isolation, to ensure adherence to infection

control protocols. Others have caught COVID-19 with direct and indirect consequences. Professional associations have alerted health managers to urgency of aligning traditional health sector values of caring and compassion to staff as well as to patients. While the public recognises and appreciates the sacrifices made by many working in health over the past year, revaluing health workers during the rolling waves of COVID-19 requires continuing top-level political and community leadership and appropriate managerial responses.

In response to COVID-19, DHBs and other agencies introduced a raft of occupational health and safety policies and procedures, staff wellbeing initiatives such as increased access to Employer Assistance Programmes and resilience and wellbeing workshops, plus daily checks, extra forms of leave and welfare assistance for those directly affected. Additionally, a raft of psychosocial impact statements were added to risk assessments. At much the same time, staff were urged to abandon their previous patterns of presenteeism if they were sick. These welcome initiatives have largely been bespoke responses to the pandemic, however.

New Zealand owes its dedicated and professional health care workforce a debt of gratitude. Health staff wellbeing in response to COVID-19 is clearly an evolving field of research and practice, but requires priority attention if New Zealand is to retain staff, value them and ensure workforce sustainability while there is limited recruitment of overseas health care professionals.

Best practice in overseas jurisdictions includes health workforce national data gathering relating to COVID-19 which could be usefully replicated. While DHBs routinely collect basic exit and sick leave data, this could be supplemented by rapid, standardised, unified whole of system reporting of absences and types of absences related to COVID-19, such as undertaken by the NHS in Scotland to provide the evidential basis for a whole of system response to health staff wellbeing.^{vi} Eight types of COVID-19 related absence, all of which apply here, are reported and monitored, providing the ability to rapidly assess the changing rates of absenteeism among the workforce and helping management respond appropriately to supporting staff.^{vii} Research into the effects of long COVID-19 should be funded appropriately and include a primary focus on health staff who have contracted one or other of the variants.

HWAB recommends to the Minister that urgent consideration be given to national human resource metrics and data collection regarding the effect of COVID-19 on the health workforce to inform wellbeing initiatives and aid staff retention.

Recovery of planned and elective care

A priority for hospital services is the acceleration in the recovery of elective care following cancellations and increased waiting times of patients during the COVID-19 response. This will be a major challenge for Health New Zealand as it begins operations on 1 July 2022. International research notes, though, that demanding performance targets and

additional funding alone are not “solutions” unless urgent health workforce issues are attended to in the short, medium and longer terms.

The health workforce has been stretched beyond tolerable limits in the past 18 months and it operates in a crucial sector with a worldwide shortage of skills. For example, New Zealand has over a 30 per cent reliance on overseas registered nurses.

Training for areas with the greatest need in elective care should be prioritised for New Zealand to reduce waiting lists. Some of the critical roles and specialisms that need attention are the shortages of theatre nurses, the need for an increased number of orthopaedic surgeons, and a dramatic expansion in diagnostic capacity plus data management staff, a variety of technical staff and anaesthetic technicians.

Given the time investment required for specialist training, the temptation to create a working group or a strategy should defer to prioritised action, exploiting the intellectual capital of dedicated health care professionals in the front line.

The expansion of joint replacement surgery alone requires up to 80 additional surgeons in New Zealand by 2026, involving a seven-year time investment.^{viii} Looking ahead, pre-replacement musculoskeletal physiotherapy may replace joint replacement in up to 30 per cent of cases, so investing in increasing the number of musculoskeletal physiotherapists in current graduate health practice programmes is equally important.

Many thousands of New Zealanders are desperately waiting for care and many have put their lives on hold with a loss of mobility, diminished employment prospects and/or increased mental health issues. While the development of regional surgical hubs, flexible private/public provision arrangements and increased operating hours may all assist in reducing waiting lists, health workforce availability is a critical determinant requiring a whole of system approach.

In the rebalancing of New Zealand's immigration policies which may see a lowering of the overall volume of immigrations, HWAB recommends an exemption for the health care sector in critical areas such as the specialisms needed to remobilise planned care.

Mental health workforce crisis

A historic lack of investment and focus on mental health and addictions staff in health workforce planning was addressed in the He Ara Oranga Inquiry into mental health and addictions. In response, the Budget-19 mental health workforce development programme focussed on three priority areas for mental health and addiction workforce development, growing the existing workforce, developing new workforces and aligning with new service delivery models by repurposing skills and competencies. To date the emphasis has been on growing the existing workforce with Budget investment targeted to support approximately 580 additional clinical FTEs into practice by 2024.

There is widespread acknowledgement of the legacy of under-investment in the

mental health and addictions workforce in New Zealand over many years. The mental health impacts of COVID-19 have greatly compounded staff shortages both in inpatient facilities and community settings and at both primary and secondary levels, and demand for a range of mental health services significantly outstrips supply. Direct and indirect COVID-19 related mental health pressures on young people, Māori and Pacific communities and the most vulnerable in the community manifest in different ways every day.

There is general sector consensus that the welcome range of initiatives to increase nursing and allied health, clinical psychology interns, nurse practitioners, health improvement practitioners, with the addition of new bursaries for Māori and Pacific students, cultural competency training and additional mental health literacy training for cross sector workforces, will not solve the current crisis, while they will alleviate short term workforce pressures and gaps.^{ix}

Early signs of the success of the Integrated Primary Mental Health and Addictions Services (Access and Choice) with health improvement practitioners and health coaches risk being overshadowed by the demonstrable unmet need highlighted by both the existence of the programmes exacerbated by increasing COVID-19 demands.

New Zealand is part of the global health care worker market, a market which places a premium on mental health professionals. Late last year a leading Australian mental health expert urged importation to double the number of mental health workers, and cited New Zealand as a prime target for catchment.^x Nationally, the health sector

is increasingly losing experienced and recently graduated mental health and addictions staff to other sectors such as Ara Poutama and Oranga Tamariki who are able to offer higher salaries and benefits. Initiatives such as the Ara Poutama Hikitia Services and expansion of the Waikeria Prison Health Services will likely further stress the available workforce for health, despite joint work to mitigate this. The Ministry will work with other agencies to grow cross-agency planning to grow and upskill the mental health and addiction workforce.

The development of well-trained, new peer and lived experience workforces that are culturally competent and that can assist in addressing primary care needs has begun and should be urgently prioritised. A new auxiliary peer workforce requires Māori and Pacific leadership to embed constructive solutions from their experience in eliminating health inequities. It could ideally harness regional Māori and Pacific training providers and incorporate lessons learnt from fast tracking auxiliary workforces, such as kaimanaaki, during COVID-19. New peer and lived experience workforces will increase capability and capacity through credentialling and could provide different pathways for Māori and Pacific workforces.

Again, the unmet and growing need for mental health and addiction services requires planning for peer workforce development to be a focus during 2022. Te Pou coordinated the 2021 development and release of the consumer, peer support and lived experience workforce development action plan. The Ministry is working with the sector to support the timely delivery of key plan actions.

Another workforce gap concerns counsellors. Counsellors in New Zealand are currently self-regulated. The Ministry is working with the leading counselling associations to implement the preferred regulatory option to allow counsellors to work as part of the funded mental health and addictions workforce. This work is proceeding with urgency.

Equally, secondary care services are critical. Long standing shortages of psychiatrists and clinical psychologists plus the turnover of registered nurses working in mental health have become endemic and difficult to address in the short term. The Ministry is committed to growing the clinical psychology workforce. It is working with regional health workforce representatives, professional leads, university coordinators and members of the Psychology Workforce Taskforce to understand and to respond to local barriers. As referred to above, this is an example where there is a demonstrable need for a "power to act" in the health workforce governance environment, following effective consultation with stakeholders.

About \$20 million of the Ministry's baseline workforce development funding is invested across the four national mental health and addiction workforce centres (Te Pou, Whāraurau, Le Va and Te Rau Ora) with \$1.325 million extra allocated to initiatives outside of the workforce centres. Each of the workforce centres have individual responsibilities and core activities. For example, Le Va is Pacific focussed; Whāraurau undertakes considerable activity for the workforce who work with children and young people; Te Rau Ora looks at Māori lived experience, leadership, frameworks and

scholarships among other work, while Te Pou incorporates leadership and system change, data information and research, basic addiction and mental health first aid education, in addition to other activities. The workforce centres, despite their strong reputation, presence and leadership in the sector, are not currently mandated to work on the undergraduate or recruitment pipeline for the workforce. Rather they have been directed toward the improvement in the skills, knowledge, quality, safety and effectiveness of the workforce. The Ministry will work with them to direct resource and expertise towards the need to also rapidly grow the multi-disciplinary workforce.

The urgent need to create new workforces and to transform existing workers with new skills and competencies plus the health reforms, provides a timely opportunity for a review of the workforce centre work programme in conjunction with leading stakeholders. The sustainability of the mental health workforce, including recruitment, training, retention and skills transformation, is critical to the success of Kia Manawanui Aotearoa: Long-Term Pathway to Mental Wellbeing, alongside the new health plan and new health structures. The Ministry is planning the next tranche of investment in growing the mental health and addiction workforce and an evaluation of what is working and what is not should be incorporated. On 1 December 2021, most of the mental health and addiction workforce contracts and funding transferred from the Health Workforce to the Mental Health and Addiction Directorate.

Māori health workforce

The vaccination campaign against COVID-19 starkly illustrates the well documented health inequities for Māori, with equity gaps for many communities including rural and harder to reach communities. A core element in Māori dissatisfaction with the mainstream prevention approach concerned limited participation from the outset of decision-making, and inadequate representation of Māori in initial service design and delivery in communities. The very low number and roles for Māori public health leaders in national and regional decision-making about population vaccination meant that iwi leaders, Māori clinicians and Māori providers, often expressed in the media that the sector's approach was out of step by not prioritising Māori from the outset. In addition the response was late to engage Māori expertise or use kaupapa Māori approaches to dealing with diverse and underserved Māori populations. Vaccine hesitancy stoked by social media, especially in the Northland region, demonstrate a current need for a better understanding by the health communicators of the nuanced, non-bureaucratic narratives needed to combat misinformation.

The virus has exposed graphically what Māori health academics, researchers, iwi leaders, and Māori providers have evidenced and experienced for decades- too few Māori health leaders, too few trained Māori health staff in regulated and non-regulated roles, and a lack of meaningful understanding by some in health leadership of the distinctive role and effective impacts of Māori staff within all parts of the system.

The experience of Māori providers during responsiveness to COVID-19 showed that strategies for encouraging vaccination based on matauranga Māori and on kaupapa Māori were singularly more successful in boosting numbers than mainstream health sector approaches. COVID-19 also again taught the health sector powerful lessons around early engagement, trust, the value of grassroots delivery, cultural safety, and the value of a kaiāwhina workforce. It is critical that this workforce is not lost, and can be built on and supported. Agile resourcing to Māori and iwi providers is required to assure this continuity.

A draft five-year Māori health workforce action plan was developed by the Ministry of Health following sector engagement. It tracks against the strategic framework of “attract, educate and train, recruit, and retain and value” and will be passed for review and possible implementation by the Māori Health Authority. Māori health workforce development is a critical element of the Ministry of Health’s Whakamaua Māori Health Action Plan and we strongly endorse the continued working together of the Health Workforce and Māori Health Directorates to support a highly effective and transformational Māori Health Workforce Development strategy.

Māori workforce development is a singular and critical challenge facing the Māori Health Authority and Health New Zealand if they are to collectively address the enduring inequities in health outcomes for Māori when compared with non-Māori, to address treaty breaches identified by the Waitangi Tribunal’s Hauora report, Wai 2575, the recommendations of the Health and Disability System Review report and

the equity aspirations outlined in the Pae Ora legislation.

There are a number of extremely successful Māori health workforce development initiatives that have been making some inroads into these health workforce inequities. Despite these initiatives, Māori health workforce gains remain incremental, and slow. It is critical to ramp up Māori health workforce development, building on the gains of these successful initiatives. This requires a whole of system and inter-sectoral level commitment and strategy, in order to achieve Māori participation, representation and leadership across the primary, secondary and tertiary workforces.

The current incremental increases are adding only one or two percentage points a year to already low totals of Māori health workers within the DHB system. The relationship between health and education sectors is critical for Māori health workforce development, and we recognise this is a priority area of outcome for the collaboration between health and education sectors described on pages 5 and 6 of this report.

The longstanding failure to address Māori health workforce inequity has failed Aotearoa New Zealand, failed Māori and Māori whānau. Some regions have done better than others with hospital and community services’ representation but this has tended to reflect local leadership initiatives rather than strong nationally-led commitment with transparent accountabilities.

Significant attention must be placed on identifying pipelines and pathways into and through existing training and

educational institutions and building new regional capability and capacity with educational providers that can ensure kaupapa Māori ways of working with Māori to increase regulated or non-regulated workforces. Understanding Māori career paths, building on knowledge that Māori who enter nursing and midwifery and other health professions are often older, promoting allied health careers to Māori students and whānau, strengthening and auditing equity accountabilities across qualifications and health sector accreditation and developing kaupapa retention strategies for Māori health workers are just some of the elements that need to be aligned.

Māori leadership and greater strategic engagement is critical to effective implementation of a different Māori health workforce strategy working with iwi, Māori health providers, Tumu Whakarae, existing school programmes feeding health pathways, existing educators especially those with a track record of working with Māori.

The current Māori under-representation in the health workforce perpetuates the marginalisation and invisibility in leadership positions, inhibits role modelling for Māori who desire health careers, restricts Māori perspectives in service problem solving and decision-making, and ultimately means too high expectations on too few. Without targeted, specific and adequate resourcing to attract, educate, develop and retain Māori health workers, nothing will change despite clear evidence of Māori health inequities.

At this juncture, retention must be prioritised in the fight against COVID-19 which means that for the booster campaign and care in the community to be successful Māori clinical and community teams, plus the kaiāwhina workforce, have to be at the forefront of decision-making and delivery to their communities. Secure, long term resourcing of Māori providers with track records has to be prioritised to secure, retain and enhance these health workers. They cannot be casualties of short term contract funding horizons, complex application and compliance processes, and slow funding flows when their capability and capacity are critical to how Aotearoa New Zealand stamps out the virus.

HWAB recommends to the Minister that co-designed procurement processes become the norm not an exception in the delivery of primary and community care to Māori, and that active workforce retention and development strategies are an integral part of funding allocations.

Pacific health workforce

The value and contribution of the Pacific health workforce was evident during the COVID-19 vaccination roll-out in 2020. Utilising their technical skills, cultural intelligence and relationships with the community they were able to significantly increase the uptake of vaccines. To date, 94% of Pacific peoples 12 years and above are fully vaccinated. The Pacific is a young population, and getting the next phase of vaccination roll out to the younger age group is critical. Only 25% of those aged 5 to 11 years have received their first vaccination. Supporting the efforts of

Pacific providers is important for success of the next phase of the campaign.

There has been various efforts including Ministry of Health strategies and guidelines to improve Pacific health over the years. However, the significant under-investment in Pacific health has hindered their impact. Investment in the Pacific health workforce to mirror the proportion of Pacific peoples (8%) is needed. Of the total health workforce, only 1% of doctors and 2-3% of nurses and fewer in other allied health professions are Pacific. The Bula Sautu report, outlines the significant under-representation of Pacific peoples in the DHB health professional workforce in every workforce category including “allied and scientific, midwifery and nursing, resident and senior medical officers”. Despite the various efforts by successive governments, there has not been a significant shift in the equity concerns and the health and wellbeing of Pacific peoples in New Zealand. We applaud the Pae Ora (Healthy Futures) Bill currently before Parliament, that includes a Pacific Health Strategy. It provides a framework for guiding the health system in its efforts to improve Pacific health outcomes. It has a specific obligation to assess current health status, performance of the health system, trends and setting of priority for services and health system improvement. One of the key priorities for Pacific health is to strengthen and build the Pacific health workforce.

The Pacific health workforce has been on the margins of workforce development for too long. There is a wellspring of concern among Pacific health professionals, academic researchers, Pacific health providers and Pacific communities about increasing health inequities.

HWAB recommends that the Pacific Health Strategy referred to in new legislation is prioritised for resourcing in 2022/3 and a target date set for completion.

Rural health workforce

While COVID-19 has stress-tested the entire health system, rural New Zealand was singularly exposed. The first COVID-19 related death occurred in a rural hospital and vaccination rates have been slower in remote, rural communities.

The response to the pandemic highlighted the chronic rural health care shortages in rural towns which are generally characterised by an average lower socio-economic status, higher proportion of Māori, older age structures and higher levels of dependency.

Research conducted during COVID-19 responsiveness highlighted the planning challenges rural hospitals faced in operating at the margins of the healthcare system. The lack of specialist intensivist and anaesthetist staff and the transfer of COVID-19 patients added to feelings of stress and isolation among rural healthcare workers.^{xi}

The Government's 2021 resident visa allowing over 5000 migrant health workers to stay in the country was welcomed as a new pathway for resident locum doctors, in particular. But rural health chiefs warned that it did not solve the vast understaffing of rural health workers and that ideally New Zealand should be training more local doctors and nurses.^{xii} The funding and expansion of rural locum services remains critical to address rural health inequities.

The 24 hospitals serving approximately 10 per cent of the population are uniquely positioned to improve health equity for rural communities, in particular Māori and Pacific peoples. But there is a need for the rural health perspective to be listened to and integral to regional service delivery whether that voice is requesting that telehealth be integrated into rural health care pathways or asking for rural prototypes to be included in any new thinking about localities. Rural consumer voices, for example, are vitally required on health consumer councils at all levels.

The development of a more strategic workforce development plan for the rural sector that focuses on the development of the rural health workforce, is a once in a generation opportunity for Health New Zealand and the Māori Health Authority.

Without it, the endemic health workforce shortages in rural towns and remote areas will continue to fuel unacceptable health inequities (outcomes and access) for Māori, Pacific and those living rurally. This is a much starker, but less visible, expression of post code lottery than DHB-by-DHB comparisons for base hospital services may reveal.

New models of care in primary and community settings need development at a local level to meet population needs and to achieve equity. Rural New Zealand could also lead digital platform development which could transform access for many in remote areas.

Aged care sector

The global pandemic has exposed the ongoing fragility of the aged care sector workforce, especially healthcare assistants

and registered nurses, working in 650 aged residential care facilities in New Zealand. Already a stressed sector, both workforce capacity and capability concerns have characterised every COVID-19 outbreak. This has involved health care assistant and nursing staff stand downs because staff-patient or patient-staff transmission of the virus, DHB nursing staff being redeployed into private aged care settings to provide capacity, and elderly, vulnerable patients being decanted into hospital wards to reduce mortality and the spread of the virus. All of these scenarios have exposed workforce pressures. Simply there are not enough aged care staff and not enough aged care staff with the right skills and training.

During the pandemic the CEO of the New Zealand Aged Care Association (NZACA), Simon Wallace, estimated a shortage of 900 registered nurses out of a workforce of 5000, nearly 20 per cent of the workforce. Registered nurses were leaving to go to DHBs for an average \$10,000 increase annually, or to become COVID-19 vaccinators. The aged residential care sector is reliant on migrant nurses and health care assistants and the gap was estimated at 350 migrant nurses waiting for MIQ spots.^{xiii}

HWAB is not involved in health sector employment relations, but pay parity and pay equity significantly impact on health workforce retention. Health New Zealand as a single employer has an opportunity to review funding formulas, in particular per bed per day regimes, to ensure that financial outcomes for staff in critical areas of the health sector are not perverse. Pay parity is a basic human right, even before pay equity considerations come into play.

Academics, researchers, industry and union representatives have been united for the past decade at least, in their calls for pay parity with DHB staff to be addressed urgently, both for registered nurses and for health care assistants. The state has an obligation to fix funding formulae that accommodate pay parity. However, large, private companies who operate with corporatized aged residential care and property models (30 per cent of NZACA's membership) also have an obligation to shareholders and the public to ensure they attract and retain qualified staff who are paid competitively, regardless of state subsidies.

HWAB recommends that pay parity differentials in the aged residential care sector be addressed as a priority employment relations consideration by Health New Zealand. Additionally, HWAB supports Ministry advice that the aged care sector, uniquely reliant on migrant labour, be exempted from any immigration restrictions that accompany immigration policy change and prioritised for MIQ accommodation.

In conclusion HWAB thanks the Minister for the opportunity to provide this Annual Report and advises that it has been prepared with stakeholder involvement from various directorates in the Ministry. HWAB welcomes the new Ministry of Disability and welcomes future opportunities for collaboration on the urgent health workforce development needed to increase, legitimise and develop the disability workforce who care for the most vulnerable of New Zealanders.

ⁱ Morrah, M. (13/08/2021) Newshub. "COVID-19 could be here for 5 to 10 years': Sir Brian Roche says NZ needs may need long-term Coronavirus response unit. Accessed 17/01/2022.

ⁱⁱ Buchan, J., Williams, G.A. and Zapata, T (2021) Governing health workforce responses during COVID-19. *Eurohealth* Vol 27, No 1.

ⁱⁱⁱ Ibid.

^{iv} Health Workforce Advisory Board minutes received 24 September, 2021.

^v Letter to Waitematā DHB Board Chair, November 2021.

^{vi} Ibid at 2.

^{vii} The eight are: Confirmed COVID-19; Staff member symptomatic; household member symptomatic; underlying health condition; caring responsibilities; test and protection isolation; quarantine; long COVID-19.

^{viii} Robertson, P. (2021) "Three essential steps to solving the elective surgery crisis." *The Spinoff*.

^{ix} Implementation of the Budget 19 Workforce development package, to grow the workforce and to increase skills and knowledge of the workforce, has made progress and has supported a number of activities including:

- more than 100 additional New Entry to Specialist Practice (NESP) places in 2021 for nurses, social workers and occupational therapists to practice in mental health and addiction
- more than 100 more places for mental health practitioners to upskill with post-graduate training in Cognitive Behavioural Therapy, infant, child and youth, co-existing mental health and substance use and specialty forensic training
- 200 new places in 2021 for primary care nurses to achieve credentialing in mental health and addiction
- the development of new Health Improvement Practitioner and Health Coach roles as part of the national rollout of new primary mental health and addiction services
- over 600 new Primary/Community FTE in place in the new Access and Choice, Māori, Pacific and Youth services
- the roll-out of a new national Nurse Practitioner Training Programme, which aims to lift the ability of all Nurse Practitioners to respond to mental health and addiction needs and to increase the currently low numbers of Nurse Practitioners specialising in mental health and addiction over time; the programme also has a focus on increasing the number of Māori and Pacific Nurse Practitioners
- new bursaries for Māori students (46 in 2021 and an additional 24 in 2022) and scholarships for Pacific students (30 in 2021 and another 35 in 2022) pursuing a career in mental health and addiction
- approximately 800 new places per annum for Māori and Pacific cultural competence training, as well as an increase in mental health and addiction literacy training for cross-sector workforces and communities.
- An initiative with RANZCP to encourage junior doctors and medical students to consider training in Psychiatry; this has a strong focus on attracting, and supporting, Māori and Pacific doctors into the specialty
- Completing a procurement process for free-to-train talking therapy and brief intervention skills available for the broad mental health and addiction workforce; these will cover both tertiary level and introductory level programmes.

The Ministry has also increased the number of funded clinical psychology internships from 8 in 2017 and 12 in 2018 to 20 in 2020 and 2021. In 2022 we have not only increased the number up to 28 but increased the funding level per internship to encourage the optimum number of interns train in publicly funded mental health and addiction services. In March 2022 a campaign will be launched to attract nurses to train and work in Mental Health. This campaign seeks to influence both new nurses and former nurses into careers into roles in Mental Health.

^x Clun, R. (October, 21, 2021). "Australia must import mental health workers to double workforce to fix crisis." *The Sydney Morning Herald*. Accessed 17/1/2022.

^{xi} Nixon, G, Blattner, K, Withington, S, Miller, R, Stokes, T (2021) "Exploring the response to the COVID-19 pandemic at the rural hospital-base hospital interface: Experiences of NZ rural hospital doctors". *New Zealand Medical Journal*. Vol 137, no 1545. 12 November. Open Access, accessed on 1/2/2022.

^{xii} NZ Doctor "New residence pathway a step forward but not a final solution for rural health workforce". Media release from New Zealand Rural General Practitioner's Network. Accessed on 1/2/2022.

^{xiii} Wallace, S. (16 July, 2021). "Crisis in Aged Residential Care exacerbated by funding outcome-90 nurses short". NZACA Media release. Accessed 17/1/2022.