# Workforce: the make or break of the health reform

## Contents

# Workforce: the make or break of the health reform

On the one hand our public hospital workforce is chronically under-staffed and exhausted. On the other hand, the health needs of our communities are growing faster than hospital and health services can keep up. In between is a growing gap of unmet health need which increases the risk of adverse outcomes, entrenches inequities, and limits quality of life.

The health system must close the gap between health needs of our whānau and health workforce capacity.

This report recommends ways to do that by focusing on actions that simultaneously (a) reduce health needs and (b) increase the health workforce capacity. This report

1. Outlines ways to reduce the need for hospital care and emphasise equitable health outcomes
2. Traces the origins of key medical workforce issues
3. Offers solutions based around the development of a sustainable medical workforce

Recommended actions are each linked to one or more of the six priorities of the Interim Government Policy Statement on Health (iGPS-Health), thereby offering some substance to these policy aspirations:[1]

1. Achieving equity in health outcomes
2. Embedding Te Tiriti o Waitangi across the health sector
3. Keeping people well in their communities
4. Developing the health workforce of the future
5. Ensuring a financially sustainable health sector
6. Laying the foundations for the ongoing success of the health sector

While this report is about medical workforce planning, with a particular focus on senior public hospital doctors and dentists, we recognise that Aotearoa New Zealand is in urgent need of a Health Workforce Strategy incorporating workforce plans from across the health professional groupings.

[1] Ministry of Health. *Interim Government Policy Statement on Health 2022-2024*. Wellington: Ministry of Health, 2022.

# Executive Summary

## Health and wellbeing for all: Reducing the need for hospital care

### Key issues

**Reduce potentially avoidable hospitalisations**: Whole-of-government action to address the social and commercial determinants of health – such as substandard housing, unsafe working practices, ending food insecurity – would reduce potentially avoidable hospitalisations.

If all hospital admissions across the deprivation quintiles equalled the least deprived quintile, this would avoid more than 250,000 hospitalisations for tamariki and rangatahi aged 0-24 every year.

**Barriers to primary care**: Primary health and dental care are our of reach for many people and whānau due to cost: in 2020/21, over 400,000 people aged over 15 were unable to access health care, and 1.5 million people were unable to access dental care. Cost exacerbates unmet need, with increased complications, co-morbidities and hospital stays.

**Lack of integration between hospital and community-based health and social services**: Integration requires understanding the flow between community, hospital and social services, as neither element can be addressed in isolation. The absence of integrated care in Aotearoa New Zealand contributes to inefficiencies, staff shortages, maldistribution of services, and is difficult for people and whānau to navigate.

Integration between community and hospital health and social services recognises a real world, holistic approach that improves health and wellbeing outcomes.

ASMS recognises that there is enough data to act now: there is no reason to wait on reports. Actions to address systemic challenges in health and other sectors will be iterative, incremental and have significant contextual detail.

| iGPS-Health priorities | ASMS recommendations for change: |
|---|---|
| 1 2 3 5 6 | **1. Reform primary and oral health services**<br>a) Eliminate user charges for primary health care and dental care<br>b) Reform primary health and dental care services to support fair population and geographic distribution |
| 1 2 3 6 | **2. Reduce potentially avoidable hospitalisation rates through whole-of-government action**<br>a) Establish a Senior Minister and a dedicated Ministry for Public Wellbeing portfolio |

b) Take a Te Tiriti o Waitangi principles approach to embed Health-for-All Policies across Ministries and government agencies
c) Match investment to meet the drivers of population health needs, including housing, education, incomes, benefit levels, and food systems

1 2 3 5 6

**3. Commit to supporting efforts at the flax-roots which integrate hospital and community-based care**

a) That Ministers of Health prioritise integrated care
b) Develop indicators of performance and outcomes that demonstrate how the needs of populations and communities, including Māori, Pasifika, disabled people, are being met

# Deconstructing the medical workforce crisis

### Key issues

**Entrenched shortages of senior doctors and dentists:** The senior medical and dental workforce continues to operate with a 22% average shortfall of senior consultants across all departments

**The Aotearoa NZ medical workforce pipeline** is affected by inadequate supply of medical graduates, as well as an ageing workforce; 15% of the workforce is aged over 65 years in 16 of the Medical Council's 28 vocational scopes, including psychiatry, dermatology, and general surgery.

**Reliance on International Medical Graduates (IMGs) but retention rates are poor:** we continue to import IMGs (second only to Israel for prevalence within the workforce) but the international market for doctors is increasingly competitive. IMGs are often not intending to stay in Aotearoa NZ, underscoring trends in the increasingly globalised medical workforce

**Sleepwalking into the future: Short on data and plans:** Aotearoa NZ urgently needs a health workforce census to understand both workforce capacity, turnover, use of locums and the divide between public and private work. It must cover workforces in primary and secondary care contexts.

A survey quantifying unmet need in secondary care is also acutely needed to support accurate service planning and forecasting.

| **iGPS-Health priorities** | **ASMS recommendations for change:** |
|---|---|
| 4 5 6 | **4. Understand workforce capacity constraints**<br>a) Undertake a regular Health Workforce Census to support strategic planning in across all health professional groups |
| 1 2 3 4 5 6 | **5. Understand unmet need for hospital and secondary care**<br>a) Complete regular population surveys to determine unmet need for hospital and outpatient care including by age, ethnicity, gender, region, deprivation status and disease prevalence |

1 2 3 4 5 6

**6. Develop a comprehensive Health and Disability Workforce Plan and Implementation Road Map**

a) Generate a gap analysis from the Workforce Census and unmet need data to form a basis for the plan
b) That the plan and principles are founded on equity, inclusion, geographic distribution, specialty, and addressing workforce shortages

1 2 3 4 5 6

**7. Investment decisions are data-driven**

a) Use the gap analysis from the Workforce Census and unmet need data to estimate current investment needs
b) Produce forecasts by speciality and match these to forecast service capacity needs

# A response to the crisis: ASMS recommendations to government

**Key issues**

**Failure to launch: repeating past recommendations:** reports dating back to 2000 show similar recommendations regarding workforce, including medical student intakes, collection of workforce data and service planning. Scant progress has been made in 25 years.

**Solutions can be unique to Aotearoa** through mātauranga Māori and Te Tiriti o Waitangi which respond to our context and address Hauora Māori, health equity, cultural safety and anti-racism

| iGPS-Health priorities | ASMS recommendations for change: |
|---|---|
| 4 5 6 | **8. Grow capacity at undergraduate level**<br>a) Increase the numbers of doctors graduating from each Aotearoa New Zealand medical school to 300 by 2027 |
| 4 5 6 | **9. Strengthen postgraduate pathways**<br>a) Engage with specialist colleges, associations, responsible authorities, and unions to improve coordination, increase flexibility and provide certainty for employment prospects |
| 3 4 5 6 | **10. Sustain support for SMOs and IMGs**<br>a) Address immediate workforce shortages in the short-to-medium term through an international recruitment strategy<br>b) Build a retention strategy for later-career SMOs and IMGs |

**11. Make cultural safety a priority for all health sector organisations**

a) Invest in the workforce and resourcing needs to build capacity in cultural safety, so that cultural loading is not an unintended outcome
b) Develop and implement cultural safety strategies that build on Te Tiriti o Waitangi, Hauora Māori, health equity, and anti-racism

**12. Approach health service design and delivery collectively, harnessing the clinical experience within the health workforce and engaging with communities**

a) That power is shared, recognising the diversity of skills and expertise within the health workforce, and the knowledge and experience of communities
b) That within health organisations, leadership is provided by workers with intimate knowledge of system operations and in relation to the vision and goals of the Pae Ora Act 2022

**13. Act to reduce the risk of future health policy failures**

a) Establish an independent Policy Costings Unit
b) Work with opposition parties to develop a cross-party political accord to enable evidence-based policies, including sustainable health and social investment, to be implemented over the longer term

## Investment check

Health Minister Andrew Little claims the Government has increased health funding by 45% since it has been in office. However, some analysis of the Government's health funding since its first Budget of 2018 gives a different picture.

**Operational investment**

The Vote Health operational Budget for 2022/23, excluding Covid-related funding ($21.39 billion), was 32.2% more than actual expenditure in 2017/18 ($16.18 billion). However, the standard "cost pressures" (inflation, wage growth and demographic adjustments), including recognition of historical cost pressures (DHB deficits), reduce that to virtually zero in real per capita terms by 2022/23.

While this is a crude analysis, it is if anything a conservative indicator of how frontline services have been affected. It does not take into account the ongoing costs of restructuring, or the resources needed for addressing patient backlogs (both of which are absorbed in operational funding).

# Health and wellbeing for all: Reducing the need for hospital care

**Key issues**

- **High rates of potentially avoidable hospitalisations**
- **Systemic barriers to accessible primary care**
- **Lack of integration between hospital and community-based health and social services**

| iGPS-Health priorities | ASMS recommendations for change: |
|---|---|
| 1 2 3 5 6 | **1. Reform primary and oral health services**<br>a) Eliminate user charges for primary health care and dental care<br>b) Reform primary health and dental care services to support fair population and geographic distribution |
| 1 2 3 6 | **2. Reduce potentially avoidable hospitalisation rates through whole-of-government action**<br>a) Establish a Senior Minister and a dedicated Ministry for Public Wellbeing portfolio<br>b) Take a Te Tiriti o Waitangi principles approach to embed Health-for-All Policies across Ministries and government agencies<br>c) Match investment to meet the drivers of population health needs, including housing, education, incomes, benefit levels, and food systems |
| 1 2 3 5 6 | **3. Commit to supporting efforts at the flax-roots which integrate hospital and community-based care**<br>a) That Ministers of Health prioritise integrated care<br>b) Develop indicators of performance and outcomes that demonstrate how the needs of populations and communities, including Māori, Pasifika, disabled people, are being met |

We estimate that currently well over half a million people have an unmet need for hospital care. Part of that is due to the Covid-related backlog of hospital treatment following the cancellation of more than 100,000 procedures and specialist appointments report in 2021. The bulk of this unmet need, however, is long-standing but had remained largely hidden until a study published in 2017 conservatively estimated it to be about 9% of the adult population. Assuming that hasn't

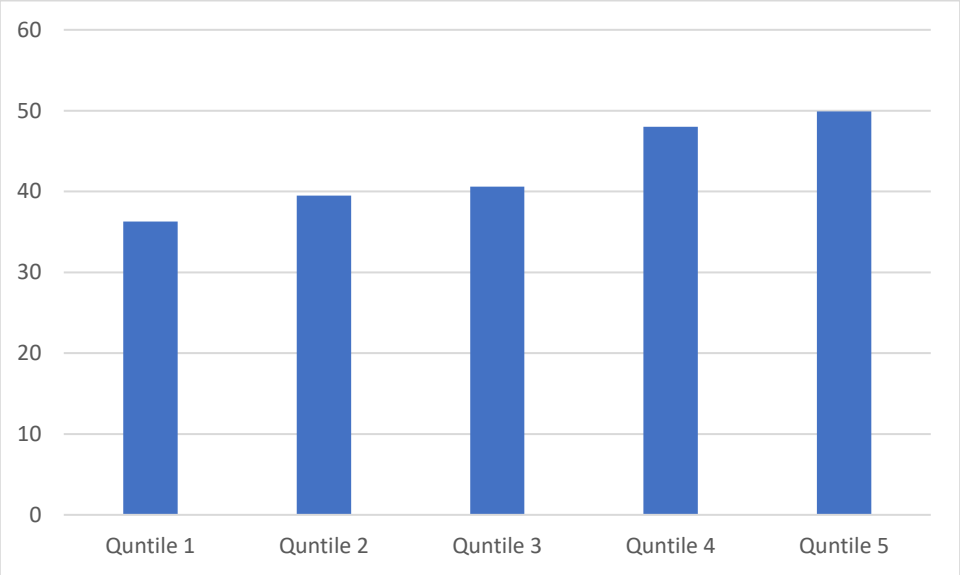
changed and the under-18s are in the same boat, that equates to about 460,000 people in 2022.[2] [3]

## Proportionate universalism: Policy pathways to equity

Addressing health workforce shortages must go hand in hand with action to reduce the rate of growing health service need, recognising the strong influence of social and economic environments on health and wellbeing, and that the more deprived the community, the worse the health outcomes – and worse still when racism and cultural alienation are added to the mix.

This is shown in potentially avoidable hospitalisation rates in Figure 1, which present a typical social gradient (Quintile 5 being the most deprived, including disproportionate numbers of Māori and Pasifika).

**Figure 1: Potentially avoidable hospitalisation per 1,000 population aged 0-24, 2020/21**




Source: National Minimum Dataset, 2022

The potential for reducing hospital admissions by addressing the socioeconomic determinants of ill health are indicated in data obtained from the Ministry of Health showing that if all hospital admissions across the deprivation quintiles equalled the least deprived quintile, more than 250,000 hospitalisations would be avoided.[4]

[2] Bagshaw P, Bagshaw S, Frampton C, et al. Pilot study of methods for assessing unmet secondary health care need in New Zealand. *NZMJ*. 2017; 130(1452):23–38.

[3] Martin H. More than 100,000 procedures and specialist appointments cancelled due to Delta, *Stuff,* 12 November 2021. https://www.stuff.co.nz/national/health/coronavirus/300451705/more-than-100000-procedures-and-specialist-appointments-cancelled-due-to-delta

[4] Ministry of Health. National Minimum Dataset, 2022.

A key Toi Mata Hauora ASMS recommendation has been to adopt a "proportionate universalism" approach to health policy.[5] [6] This requires action across the whole of society, focusing on those social factors that determine health outcomes. It requires a whole-of-government response with strong partnerships across six key areas: early child development, education, employment and working conditions, household income, healthy environments in which to live, work and play, and a social determinants approach to prevention.[7]

It also requires cross-party political accords to ensure policies, based on the evidence, are sustained over the longer term. This is discussed further at the end of this paper.

For further information, see *Creating Solutions Te Ara Whai Tika* and *Health Matters,* available on the Toi Mata Hauora ASMS website.

## Improve access to primary health care and dental care

An estimated 424,000 adults had an unmet need for primary care due to cost in 2020/21, and well over 1.5 million adults were estimated to have an unmet need for dental care due to cost in the same period. Barriers to primary care are disproportionately experienced by Māori and Pasifika whānau, and people on lower incomes, than other communities.[8] [9] [10] While reducing those barriers by eliminating GP and dentist fees may not on its own reduce hospital inpatient admissions overall,[11] at least in the current primary care system, it will help reduce the rates of complications, and the lengths of hospital stays, and improve health outcomes.[12] [13]

Removing cost barriers to primary care and dental care can also reduce pressure on hospital Emergency Departments (EDs),[14] [15] which are continuing to see a growing number of patients, increasing by nearly 23% between 2011 and 2021. Case acuity is also on the rise (62% of cases being

---

[5] ASMS, Canterbury Charity Hospital Trust. *Creating Solutions Te Ara Whai Tika: A roadmap to health equity by 2040, 2021.* *https://issuu.com/associationofsalariedmedicalspecialists/docs/asms-creating-solutions-fa-web_-_final*

[6] ASMS. *Health Matters: Framing the full story of health*, ASMS, October 2020. https://issuu.com/associationofsalariedmedicalspecialists/docs/health_matters

[7] Marmot M. *Fair Society, Healthy Lives: The Marmot Review: Strategic review of health inequalities in England post-2010.* London: The Marmot Review.

[8] ASMS, Canterbury Charity Hospital Trust. *Creating Solutions Te Ara Whai Tika: A roadmap to health equity by 2040, (p17-19), 2021*

[9] Jeffreys M, Smiler K, et al. *Prevalence and Consequences of Barriers to Primary Health Care*, Ministry of Social Development and Victoria University of Wellington. March 2021.

[10] Ellison-Loschmann L, Firestone R, et al. Barriers to and delays in accessing breast cancer care among New Zealand women: disparities by ethnicity, *BMC Health Services Research* (2015) 15:394

[11] ASMS. Does more access to primary care and a greater focus on preventing illness and promoting health reduce pressure on hospital services? ASMS *Research Brief,* Issue 12, 2019. https://www.asms.org.nz/wp-content/uploads/2022/05/Research-Brief-on-primary-prevention_170857.2.pdf

[12] Santosh J, Crampton P. Do financial barriers to access to primary health care increase the risk of poor health? Longitudinal evidence from New Zealand. *Social Science and Medicine*, 288. 113255, 2021.

[13] RANZCP. *Minding the gaps: Cost barriers to accessing health care for people with mental illness*, 2015.

[14] Lu K, Xiong X, Horras A*, et al.* Impact of financial barriers on health status, healthcare utilisation and economic burden among individuals with cognitive impairment: a national cross-sectional survey. *BMJ Open* 2022;12:e056466

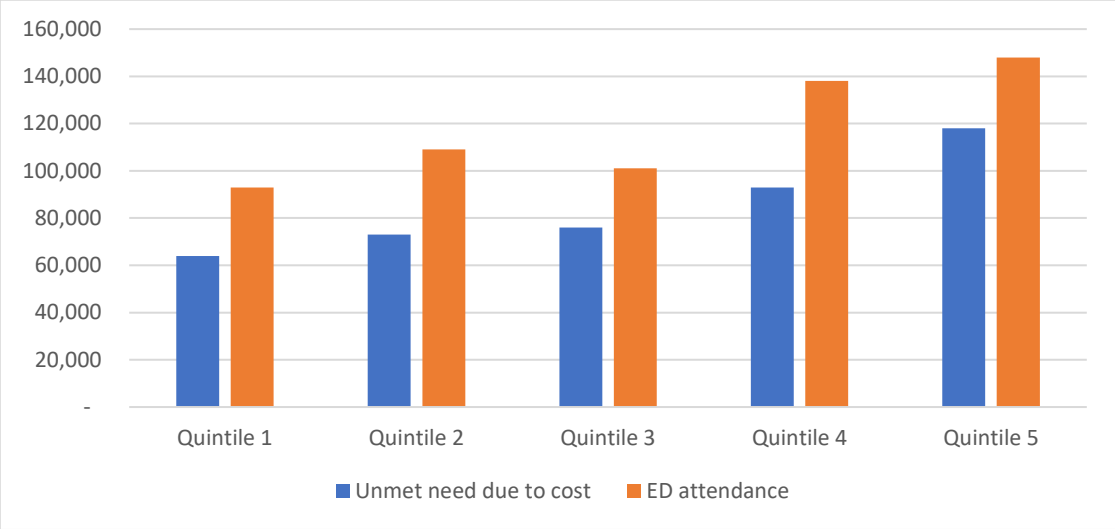
[15] McKenzie J, Yap M, et el. A five-year retrospective observational study of dental presentations to Waikato Hospital's emergency department, *NZMJ,* 2022 Mar 11;135(1551):95-105

"immediately or potentially life-threatening" in 2021 compared to 50% in 2011), suggesting that people and whānau are delaying seeking help due to barriers in access, and an increased severity in illness.[16]

A review of a recent scheme to relieve ED pressure at Middlemore Hospital by providing free GP care over two weekends in the Counties-Manukau District was inconclusive due to shortcomings in its design and implementation. However, the initiative did highlight the lack of primary care service capacity to meet growing health need in the area. [17]

Figure 2 indicates increasing unmet need and ED use for communities with higher rates of hardship and deprivation. Data on unmet need for dental care due to cost shows a similar pattern.[18]

**Figure 2: Adult unmet need for primary care due to cost, and ED visits, by quintile 2020/21**




Source: NZ Health Survey 2020/21

Barriers to accessing primary care are worsened by the maldistribution of GP practices, creating dire shortages in areas such as South Auckland and contributing to an estimated 950,000 children, adults and whānau not being able to get an appointment at their usual medical centre within 24 hours when they wanted to.[19]

> *A key is issue for the health system is the inability to control where doctors set up practice. There is significant variation across districts in the ratio between the number of GPs and the size of the population. It is unlikely that this will change unless appropriate incentives are found to draw GPs to under-served and rural areas*.[20]
>
> - *Evaluation of Primary Care Strategy, 2013*

[16] Ministry of Health. National Minimum Data Set, 2022.

[17] Jackson G, Old A, Bennett W, et al. *Review of the Counties Manukau Free Primary Care Initiatives*, Te Whatu Ora Health New Zealand, 30 August 2022.

[18] Ministry of Health. NZ Health Survey 2021/22.

[19] NZ Health Survey 2020/21.

[20] Raymont A, Cumming J. *Evaluation of the Primary Health Care Strategy: Final Report*. Wellington: Health Services Research Centre, Victoria University of Wellington, September 2013.

The same goes for access to dentists, where there is a three-fold difference between the best-served and worst-served districts in terms of the number of dentists and dental specialists per capita.[21]

## Integrate hospital and community-based services

To relieve increasing pressure on hospitals – and community-based services – the evidence shows a whole-system perspective is needed, adopting an integrated approach that recognises the 'real world' complexities of modern health care and how to support whānau needs.

Finding ways to successfully integrate health services is becoming more urgent as demand for health services grows, with an increasing prevalence of people with multiple morbidity, and increasing complexity of health care requiring strong collaboration between hospitals and community-based services. The focus cannot be on community care alone (the current policy response) as the introduction of interventions in community care will often create flow-on implications for hospital care, and vice versa.

When initiatives to integrate services are planned and implemented well, they can achieve significant improvements in the quality and effectiveness of services and reduced rates of hospital admissions. But many attempts at integrating services have not produced the hoped-for results. There are various reasons for this, including a lack of long-term investment; over-ambitious political expectations in short-timeframes; poorly prepared environments, including staff shortages, for establishing the conditions for change; and poorly informed attempts to integrate services from top-down directives. [22] [23] [24]

There is no 'one size first all' model for integrating services because integration can take many forms and the requirements for implementing change are determined largely by local context. However, there are common elements that are critical for success. These include:

- Integration requires upfront and long-term investment recognising that it takes time to produce measurable and sustainable benefits.
- Integration must start from the 'flax-roots' and is a highly organic and adaptive process.
- Integration requires high levels of ongoing dialogue, debate and discussion at all levels to achieve shared understanding about quality problems and solutions. This requires collective leadership; that is, leadership that is not focused on a few 'heroic' individuals in formal leadership roles but is shared and distributed as a collective responsibility.

---

[21] ASMS. *Tooth be told: The case for universal dental care in Aotearoa New Zealand*, 2022. https://issuu.com/associationofsalariedmedicalspecialists/docs/asms220501-tooth_be_told

[22] ASMS. The path to integrated care, *Research Brief* Issue 17, 2019. https://www.asms.org.nz/wp-content/uploads/2022/05/Research-Brief-on-integrated-care_172441.2.pdf

[23] Blank L, Baxter S, Woods HB, et al. Referral interventions from primary to specialist care: a systematic review of international evidence, *Br J Gen Pract* 2014.

[24] [24] Primary Care Workforce Commission (UK). *The future of primary care Creating teams for tomorrow*, Report by the Primary Care Workforce Commission, July 2015

The ‘Canterbury Initiative’, which includes many of the features considered important to successful integration, has been recognised here and internationally as an example of how to implement changes to achieve better community-hospital care integration.[25] [26] Similar to experiences overseas, however, it has been constrained by funding and staffing shortfalls, which have limited its transformative potential.

[25] Timmins N, Ham C. *The quest for integrated health and social care: A case study in Canterbury, New Zealand*. The King’s Fund, London, 2013.

[26] McGeoch G, *et al. Journal of Primary Health Care* 2022; 14(1): 6–9.

# Deconstructing the medical workforce crisis

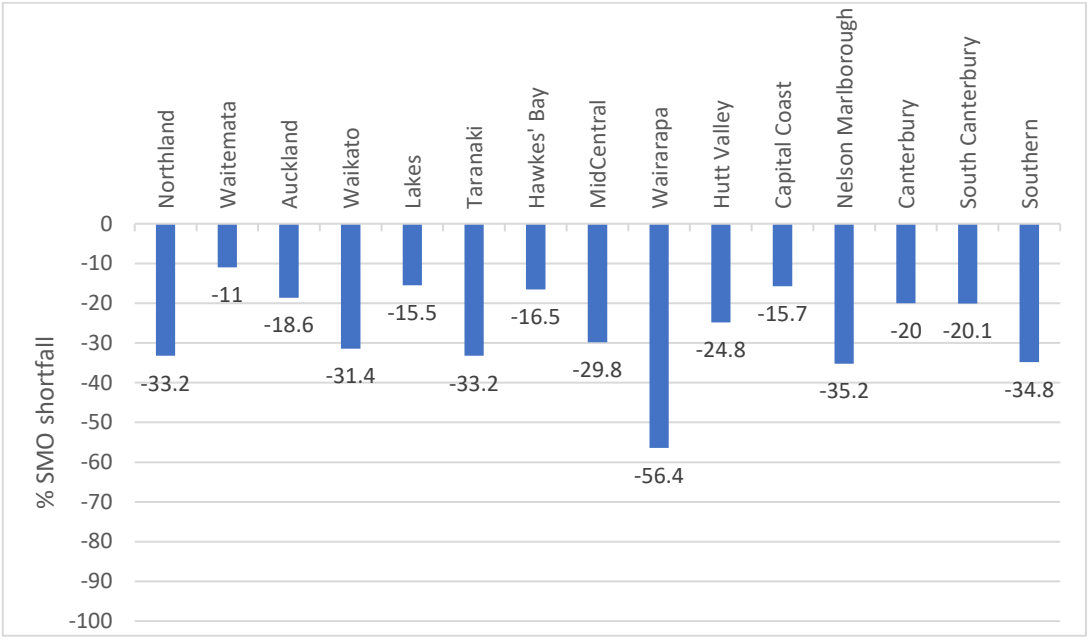
**Key issues**

- **Entrenched shortages of senior doctors and dentists**
- **Inadequate supply of medical graduates and an ageing workforce affect the Aotearoa NZ medical workforce pipeline**
- **Reliance on International Medical Graduates (IMGs) but retention rates are poor**
- **Sleepwalking into the future: No data, no plan**

| iGPS-Health priorities | ASMS recommendations for change: |
|---|---|
| 4 5 6 | **4. Understand workforce capacity constraints**<br>Undertake a regular Health Workforce Census to support strategic planning in across all health professional groups |
| 1 2 3 4 5 6 | **5. Understand unmet need for hospital and secondary care**<br>Complete regular population surveys to determine unmet need for hospital and outpatient care including by age, ethnicity, gender, region, deprivation status and disease prevalence |
| 1 2 3 4 5 6 | **6. Develop a comprehensive Health and Disability Workforce Plan and Implementation Road Map**<br>Generate a gap analysis from the Workforce Census and unmet need data to form a basis for the plan<br>That the plan and principles are founded on Equity, Inclusion, Geographic Distribution, Specialty, and Addressing Workforce Shortages |
| 1 2 3 4 5 6 | **7. Investment decisions are data-driven**<br>Use the gap analysis from the Workforce Census and unmet need data to estimate current investment needs<br>Produce forecasts by speciality and match these to forecast service capacity needs |

# The SMO workforce capacity in 2022

**Figure 3: Average SMO staff shortfalls in 15 health districts estimated by clinical heads of department in 2022**




Source: ASMS 2022

Clinical Directors across 15 districts were surveyed in early 2022 to establish their assessments of safe staffing levels in their departments, taking into account access, quality, safety, and unmet need. The surveys found an average 22% shortfall of senior medical officers across all departments (Figure 3).[27]

Extrapolating those results to the total national workforce, this would amount to a shortfall of approximately 1,140 full-time equivalent SMOs.

Chronic staffing shortages have contributed to high levels of burnout. In a Toi Mata Hauora ASMS survey of members published in April 2021 nearly 50% of respondents reported burnout – meaning there has been no substantive improvement since our last burnout survey in 2015.[28]

The Ministry of Health has projected Aotearoa New Zealand's medical specialist workforce (public and private) to increase by 20%, between 2021 and 2031, based on historical trends of workforce entry and exit rates by age group, over the last five years.[29] This is virtually identical to workload projections, based on case-weighted public hospital discharge rates projected in five-year age groups to 2031.

In other words, SMO workloads will continue at current levels unless there is substantial improvement in recruiting and retaining more public hospital SMOs (Figure 4). This assumes, also,

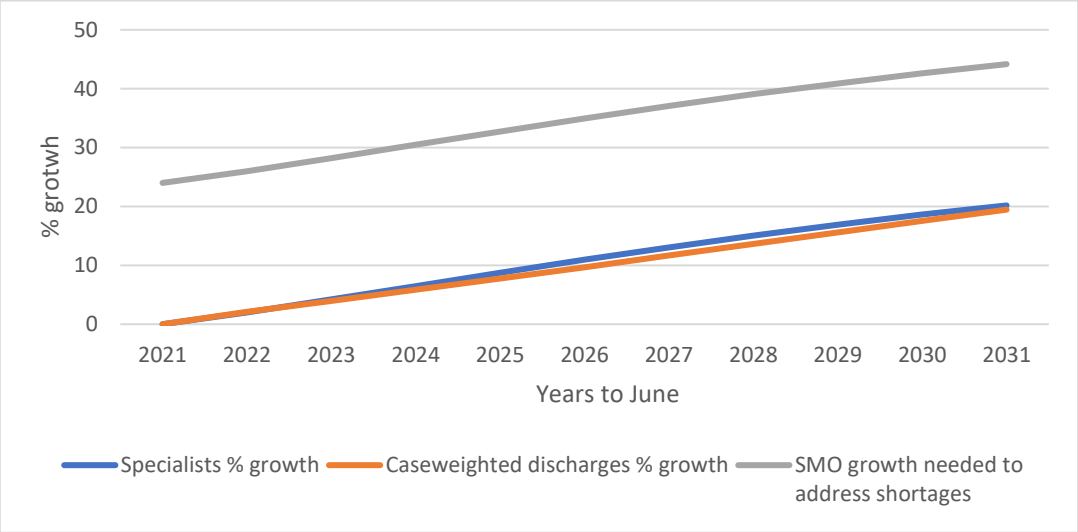
[27] ASMS. Surveys of clinical leaders on Senior Medical Officer (SM0) staffing needs, 2022. https://www.asms.org.nz/publications/researchbrief/

[28] Chambers C, 'My employer is exhausting' – Burnout in the senior medical workforce five years on, *Health Dialogue*, Issue 17, April 2021. https://www.asms.org.nz/wp-content/uploads/2021/05/Health-Dialogue-Burnout.pdf

[29] Ministry of Health. Unpublished medical specialist workforce projections, 2021-2031.

that the proportion of specialists working full-time or part-time in the private sector remain constant, but preliminary results from a recent survey by Toi Mata Hauora ASMS indicates a possible significant shift towards the private sector – to be reported on later.

**Figure 4: Projected growth in specialist workforce and workload, 2021 to 2031**




Sources: Ministry of Health; ASMS

Drilling down on the survey data, working at current levels means:

**Many HoDs struggle to find time for leadership duties.** Just 58% of respondents said they had time for leadership duties "often" or "always".

**Many SMOs lack time for training duties:** On average, 48% of respondents disagreed or strongly disagreed that their department's staffing levels were adequate to allow sufficient time for training and supervision duties.

**Many SMOs lack time for continuing medical education (CME):** On average, 41% of respondents agreed or strongly agreed that their departments had sufficient internal cover for staff CME. Almost as many (38%) disagreed or strongly disagreed.

**Many departments have insufficient staff cover for leave taking:** On average, nearly half of respondents disagreed or strongly disagreed that their departments had sufficient internal cover for sick leave and annual leave.

**Many departments struggled to find locums:** On average, only 15% of respondents agreed or strongly agreed their departments had sufficient access to locums.

## Growing the Māori medical workforce

Māori health and wellbeing is guaranteed under Te Tiriti o Waitangi, meaning the Crown is obliged to protect Māori health as a taonga, and ensure Māori have the same rights and privileges as non-Māori, such as the right to accessible health care.

Despite the commitments under Te Tiriti, systemic and structural oppression has baked in health inequities for tangata whenua. At 17% of the population, Māori disproportionately experience the worst health outcomes of any group in Aotearoa, and are severely underrepresented in the senior medical workforce, comprising just 2.1% of senior doctors in 2021. [30]

Māori workforce development in particular is considered by the Health Workforce Advisory Board as "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".[31]

University policies to encourage and support Māori and other minority groups to have better access to medical schools has resulted in Māori annual medical school intakes to double since 2009. In 2021 there were 491 Māori students enrolled (18% of domestic enrolments), and 60 Māori doctors graduated from the University of Otago's Medical School.[32] [33]

However, a Medical Council/Te Ohu Rata o Aotearoa (Te ORA) report on cultural safety within vocational medical training has found progress has been slow in many areas, with some medical colleges providing effective strategic and practical support structures for Māori trainees and fellows, while others are just getting started. Notably, the report found that "Significant effort is still needed to recruit and retain Māori trainees to address population-based equity issues."[34]

While most Māori fellows and trainees experience largely positive interactions with their non-Māori colleagues, some "face challenging situations with trainers who do not understand cultural safety or have a primary commitment to health equity for Māori". And many experience "cultural loading", with an expectation that they will take on additional duties such as reviewing research proposals for Māori responsiveness, or providing translations in Te Reo Māori, for which they do not always receive adequate support nor training, and are often unpaid.

An earlier Medical Council/Te ORA report noted: "The current doctor workforce includes a group of doctors who consider that they 'treat everybody the same' and do not need to change or adapt their processes to accommodate a range of cultural groups. This cohort is typically, but not exclusively, of Pākehā ethnicity and completed training prior to 2000. These doctors expressed discomfort with the idea that they may be biased and expressed that they did not see value in attending education sessions or undertaking reflective practice activities focused on cultural safety. These doctors did not respond to the current suite of mechanisms embedded in the system to prompt them to enhance

[30] TAS. *District Health Board Employed Workforce Quarterly Report, 1 January to 31 March 2022*.

[31] Health Workforce Advisory Board. *Annual Report to the Minister of Health*, January 2022.

[32] Medical deans of Australia and New Zealand. *Student Statistics Report 2021, September 2021.*

[33] University of Otago. Record Māori health professional cohort celebrated. https://www.otago.ac.nz/news/news/otago835258.html

[34] Carter M, Potiki M, Haggie H, Tipene-Leach D. *Cultural safety within vocational medical training.* Report of Te ORA and the Council of Medical Colleges, May, 2021

the cultural safety of their practice and present a challenge for efforts to develop an environment of culturally safe care." [35]

The Health Quality and Safety Commission (HQSC) reports that not only are health services less accessible for Māori, there are also impacts across the life course independent of socioeconomic status: maternity services do not meet the needs of hapū mama and whānau; Māori are more likely to experience long wait times for specialist referrals, and older Māori living with disability are more likely to experience unmet need when trying to access specialised equipment.[36]

HQSC identifies actions at the systems, network, organisational and individual levels to eliminate health inequities for Māori, which draw on the themes of being:

People-driven: services are developed *with* people, rather than *for* people, and uphold ways of being, doing and knowing. In this way, health and other services are designed by Māori, for Māori, as Māori.

Power is shared: cultural safety recognises that all individuals and institutions have biases, and that these assumptions and attitudes are expressed, often unconsciously, in clinical encounters and service design and delivery.

*"Cultural safety recognises that understanding and confronting power imbalances and racism, both within health services and among the individuals who work in them, disrupts the cycle of victim-blaming and shifts responsibility back on to institutions and health workers to address the poor performance of services in meeting the health rights of Māori."*

*Health Quality and Safety Commission*

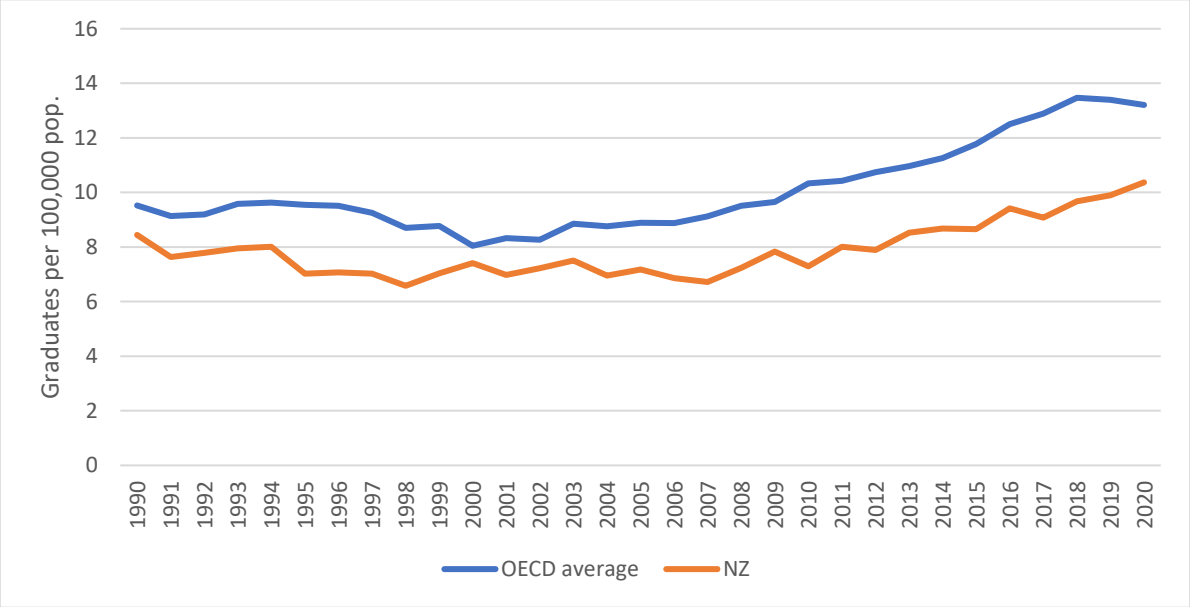
[35] Simmonds S, Carter M, et al. *Baseline Data Capture: Cultural Safety, Partnership and Health Equity Initiatives*, Medical Council of New Zealand and Te Ohu Rata o Aotearoa, Wellington, October 2020.

[36] Health Quality and Safety Commission. A window on the quality of Aotearoa New Zealand's health care 2019 – a view on Māori health equity. Wellington: Health Quality and Safety Commission; 2021. Available from https://www.hqsc.govt.nz/assets/Our-data/Publications-resources/Window_2019_web_final-v2.pdf.

## Supply shortcomings: Not enough doctors trained locally

Aotearoa New Zealand has had one of the lowest numbers of medical graduates per head of population in the OECD for many years. Despite an increase in medical school intakes over recent times, the gap between our graduate numbers and the OECD average has also increased (Figure 5). Current Aotearoa New Zealand projections indicate a downward trend after 2020.[37]

**Figure 5: Medical graduates per 100,000 population – NZ and OECD average, 1990-2020**




Source OECD Health Data 2022

Consequently, to attempt to fill the medical workforce gaps, Aotearoa New Zealand has the second-highest proportion of international medical graduates (IMGs) among OECD countries (behind Israel), including 45.4% of the existing specialist workforce.

While IMGs play a critical role in filling substantial specialist workforce gaps, especially in regional Aotearoa, such a heavy dependency leaves the health system vulnerable to changes in supply, recruitment and retention in other countries. Two key issues have emerged:

- Increasing competition to attract IMGs
- Poor retention rates of IMGs

### International competition for doctors

International competition for doctors is increasing. Despite efforts in many OECD countries to become medically self-sufficient by training more doctors (many of whom subsequently have difficulty finding positions because of resource and capacity constraints), significant shortages are forecast. The United States alone is estimated to be facing a shortage 124,000 physicians by 2034,

[37] Medical Deans of Australia and New Zealand. *Student Statistics Report 2021, September 2021.*

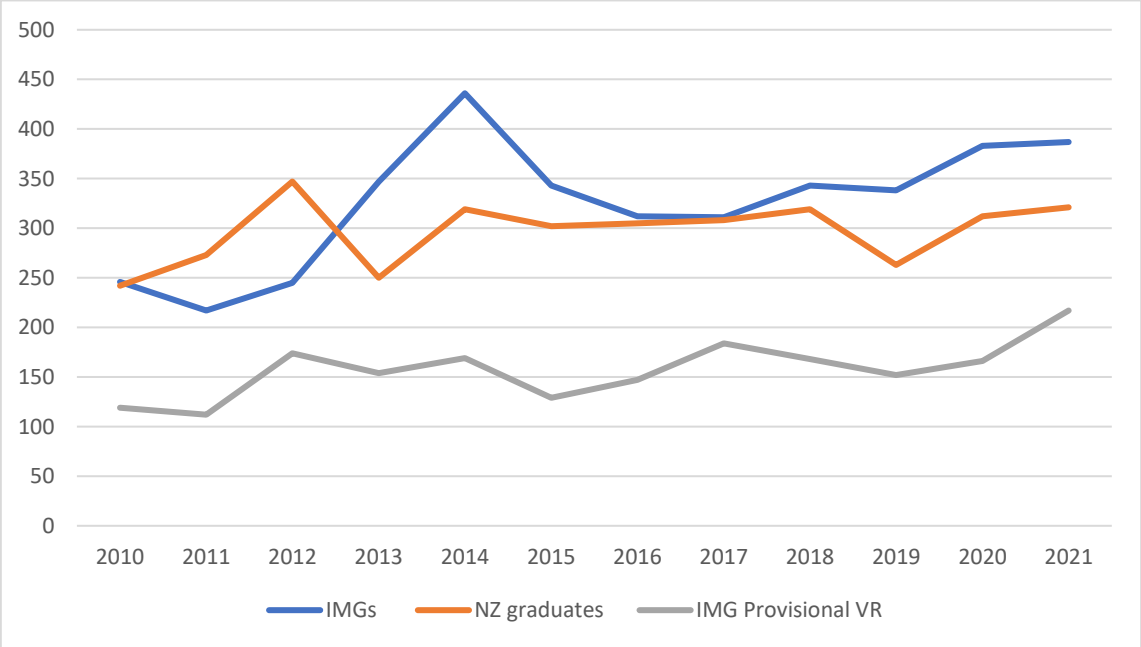
including shortfalls in both primary and hospital care.[38] In the UK, Aotearoa New Zealand's main source of IMGs, the British Medical Association reports that as of June 2020 there were 8,278 NHS consultant vacancies – an underestimate of actual shortages.[39]

Trends in new vocational registrations and provisional vocational registrations indicate Aotearoa New Zealand's continuing heavy reliance in recruiting IMGs (Figure 6). Nevertheless, 62% of respondents to the clinical heads of department survey in early 2022 cited difficulties in recruiting SMOs. This will be a conservative indicator of recruitment issues as the same respondents estimated the number of formal vacancies was less than half of the SMO staffing needed to provide the best quality care. To fill the workforce gaps, new vocational registration trends shown in Figure 6 will need to rise more sharply, and the limited supply of locally trained doctors will necessitate continuing dependence on recruiting from overseas for the foreseeable future.

A 2008 OECD paper on Aoearoa New Zealand's position regarding international recruitment commented: "[T]aking into account the fact that the annual numbers of health professional immigrants to New Zealand are relatively small compared [with] the scale of worldwide flows, it is most likely that New Zealand will be able to recruit the doctors and nurses it needs but at an increasing cost with increasing difficulties to attract the best skills."[40]

Retention of those doctors, however, is a major challenge – exacerbated by ageing medical workforces internationally.

**Figure 6: New vocational registrations and provisional vocational registrations, 2010-2021**




Source: MCNZ Annual Reports 2010-21

[38] AAMC. *The Complexities of Physician Supply and Demand: Projections From 2019 to 2034*, Association of American Medical Colleges, June 2021.

[39] BMA. *Consultant workforce shortages and solutions: Now and in the future,* British Medical Association*, 2020.*

[40] P Zurn and J-C Dumont, *Health Workforce and International Migration: Can New Zealand compete?* Health Working Paper No. 33, Organisation for Economic Co-operation and Development, Paris, 2008, p 44.

## The ageing workforce

A European Commission report notes the aging health workforce is leading to an "upcoming massive replacement need, even with gradually growing workforce sizes".[41] Trends towards greater work-life balance, and the increasing proportion of women in the specialist workforces of Western countries underscores the need to increase the numbers of medical specialists internationally.

In 2022, a national survey of Toi Mata Hauora ASMS members on their career intentions within the next five years found 36% of respondents aged 55 and over were either likely or extremely likely to leave medicine entirely. A 2017 medical workforce taskforce noted "it is essential that we adequately plan for an aging specialist workforce and have enough junior doctors in training to replace them", reported there were 19 district health board specialties with fewer trainees than there were specialists aged 55+.[42]

In 2022 there were 28 specialties with fewer trainees than there were specialists (private and public) aged 55+ (Table 1). Those in red indicate at least 15% or more of the workforce is aged 65+.

### Table 1: Specialties with fewer trainees than specialists aged 55+, 2022

| | |
|---|---|
| **Anaesthesia** | **Oral & Maxillofacial Surgery** |
| **Cardiothoracic Surgery** | **Orthopaedic Surgery** |
| **Clinical Genetics** | **Otolaryngology Head & Neck Surgery** |
| **Dermatology** | **Paediatric Surgery** |
| **Diagnostic & Interventional Radiology** | **Pain Medicine** |
| **Family Planning & Reproductive Health** | **Palliative Medicine** |
| **General Practice** | **Pathology** |
| **General Surgery** | **Plastic & Reconstructive Surgery** |
| **Medical Administration** | **Psychiatry** |
| **Musculoskeletal Medicine** | **Public Health Medicine** |
| **Neurosurgery** | **Rehabilitation Medicine** |
| **Obstetrics & Gynaecology** | **Sexual Health Medicine** |
| **Occupational Medicine** | **Urology** |
| **Ophthalmology** | **Vascular Surgery** |

Source: Ministry of Health 2022

## Retention

### After general scope registration

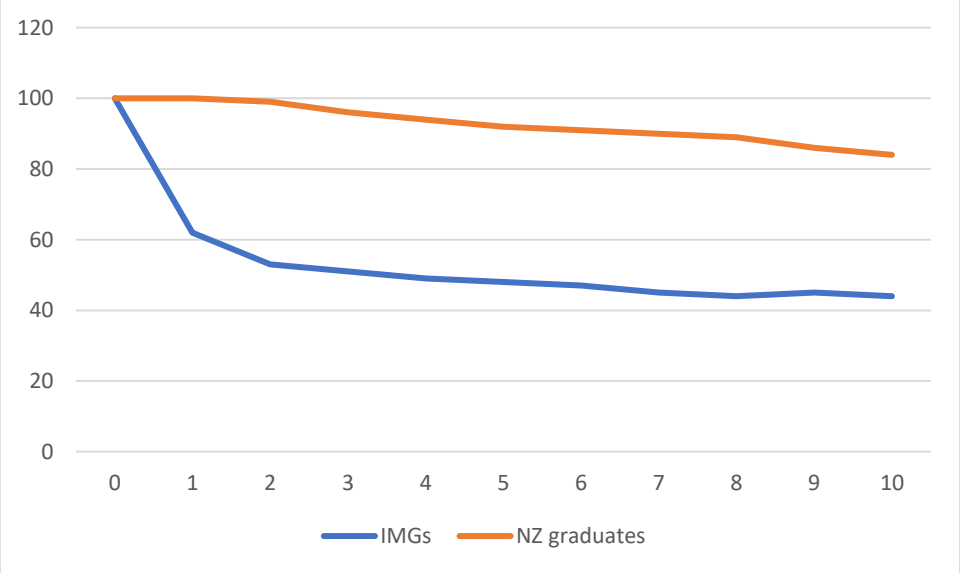
[41] European Commission. *Mobility of health professionals: Final Report Summary*, 2016.

[42] Health Workforce NZ. Meeting agenda and minutes from previous meeting, Medical Taskforce Governance Group, 13 September 2017.

Many IMGs do not come to Aotearoa New Zealand intending to stay indefinitely: many come to fill locum positions as part of a working holiday before travelling on to other countries. For those that stay on to obtain registration in general scope of practice, again many don't intend to reside in Aotearoa long-term. An average of just 62% are still working in Aotearoa New Zealand one year later, based on retention rates since 2010. This decreases steadily to average of 44% after 10 years (Figure 7).

While the number of IMGs has increased over the past 20 years, the retention rates are getting worse. In the decade 2000-2009, average retention rates were 82% after one year and 55% after 10 years.

**Figure 7: Retention of IMGs and NZ graduates after general scope registration, based on average retention rates since 2010**




Source MCNZ 2022

In contrast, Aotearoa New Zealand graduate retention rate is virtually 100% after the first year, falling to an average 84% after 10 years. Interestingly, after the initial two years post-registration, IMG attrition rates are similar to those of Aotearoa New Zealand graduates.

**After vocational registration**

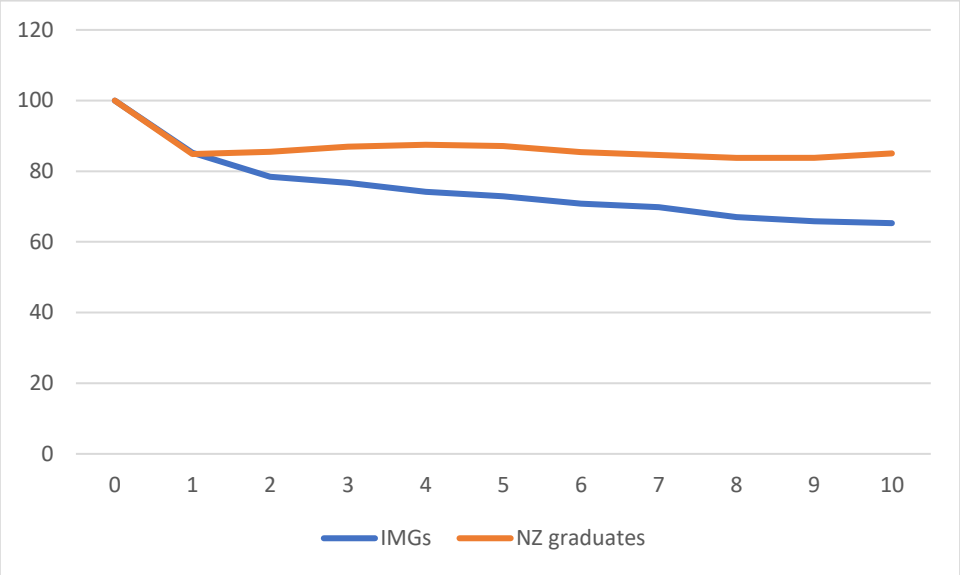
Retention rates for both Aotearoa New Zealand graduates and IMGs are similar one year after obtaining vocational registration (85% for both). From then onwards, Aotearoa New Zealand graduate rates stabilise while IMG rates fall steadily to 65% after 10 years (Figure 8).

The Medical Council suggests: "A possible contributing factor to this reduced retention is that IMGs are likely to be older and at a later stage in their careers when they gain their vocational scope compared to New Zealand graduates, as many will have already been practising as specialists before coming to New Zealand. Because of this, their retention is more likely to be affected by doctors who are retiring from medical practice."[43]

[43] MCNZ. *The New Zealand Medical Workforce in 2016*.

It is not clear why 15% of new vocational registrants leave after the first year. It appears these doctors have decided to pursue their specialist career overseas but may be leaving their options open should they decide to return to Aotearoa New Zealand in the future.

**Figure 8: Retention of IMGs and NZ graduates after vocational scope registration, based on average retention rates since 2010**




Source MCNZ 2022

## Untapped potential to harness the knowledge and skills of clinicians to transform health care

To meet the challenges facing today's health care systems and make the most of the potential opportunities of the future, the strategies, tactics, and leadership approaches that may have worked in the past are no longer fit for purpose. Instead, health service leadership must be distributed to those with intimate knowledge of the day-to-day workings of a service and are best placed to find innovative solutions to the many 'wicked problems' facing modern health care and to understand how to improve organisational performance and influence care practices.[44]

When frontline clinicians and other health professionals have an opportunity to lead, with support from their organisations, they have been shown to have a meaningful impact on reducing acute admission hospital rates, reduce unwarranted variation in medical practice and improve the performance of their organisation financially and clinically in multiple ways.

Despite Health Ministers and other prominent officials over the last two decades recognising the significant potential of clinical leadership, and promoting policies to implement it, it has struggled to gain much traction in Aotearoa NZ.

[44] ASMS. Collective leadership: harnessing the knowledge and skills of clinicians to transform health care, *Research Brief*, Issue 18, 2019. https://www.asms.org.nz/wp-content/uploads/2022/05/Research-Brief-Distributed-clinical-leadership_172592.2.pdf

The authors of a series of papers examining leadership in complex health environments concluded that: “Perhaps the biggest barrier to these [relational] approaches prompted by complexity thinking are the incumbent leaders of health systems who have risen within the hierarchy based on command and control methods”.[45]

Attempts to bring about transformational change have also been thwarted by funding constraints, combined with consequential staff shortages and government expectations to meet its performance targets, which means many clinicians and other health staff have no time to engage in service improvement initiatives.

National surveys of ASMS members in 2010 and 2018/19, found in both cases that just 20% of respondents agreed they had sufficient time to engage in distributed clinical leadership.[46]

*Globally, clinical leadership - the active engagement of doctors and nurses in how health services are provided - is recognised as the fundamental driver for better health outcomes. Yet here in New Zealand over the past decade, the influence of clinicians on patient outcomes has been less than ever before. This failure to engage the very people with the right expertise - doctors and nurses who know the patients' needs best - is seriously eroding our ability to provide patients with the care they need.*

- Hon Tony Ryall, Minister of Health, 2009[47]

[45] Plsek P, Wilson T. Complexity, leadership, and management in healthcare Organisations *BMJ* 2001;323:746–9

[46] Powell, I. Little progress in distributed clinical leadership, *The Specialist*, Issue 120 (p21-22), October 2019.

[47] Ryall, T (Hon). Address to the Dean’s Winter Lecture Series, AUT, 16 October 2009. https://www.beehive.govt.nz/speech/tony-ryall-speech-governments-health-agenda

## Lack of good data on the medical workforce and health needs

The SMO Commission of 2008, reporting on sustainable conditions of employment for senior doctors and dentists, noted:

*Our ability to make decisions based on good evidence has been compromised by an extraordinary lack of reliable and objective workforce management information. This is symptomatic of the lack of accountability and priority for workforce planning and management, which is even more remarkable given that the health system is a particularly labour-dependent industry.*

In 2020 the Health and Disability System Review found the same problem:

*Developing workforce plans will require more comprehensive and accurate data than is currently available. Sector-wide workforce data is not routinely collected, accurate or consistent, making it difficult to access and use this information.*[48]

While medical workforce data is reported to be better than that of most other health occupations, basic gaps remain, and what is available is often not robust. TAS's quarterly public hospital workforce reports, for example, overstate the SMO workforce due to double counting where SMOs work across local districts, and FTE data is inconsistent.

No government agency has attempted an SMO workforce/health needs gap analysis. Toi Mata Hauora ASMS is the only organisation to have done so. There is little information on retention and turnover rates for SMOs, or use of locums. There is little reliable data on the private hospital medical workforce or the number of SMOs (headcounts and FTEs) who work in both the public and private systems.

In primary care, there is wide variation on the estimated size the GP workforce. A report by consultants Allen + Clarke, supported by the Royal New Zealand College of General Practitioners, indicated 74 GPs per 100,000 population in 2021 (approximately 3,800 GPs) but that excludes non-vocationally registered GPs and appears to include doctors with Urgent Care vocational registration.[49] The Ministry of Health estimated 4917 GPs in 2020 (a figure reported by the OECD), which includes trainee GPs but excludes Urgent Care doctors.[50] The Ministry of Business, Innovation & Employment estimated in 2021 "around 5,500" GPs but did not provide a GP definition or quote a source. Currently no government agency routinely collects data on the wellbeing of the medical workforce.[51]

Some useful progress has been made by the Ministry of Health – and now Te Whatu Ora Health New Zealand – on specialist workforce forecasts, and in some cases workforce forecasts against projected service use. However, these forecasts understate future requirements as they don't take

[48] Health and Disability System Review. 2020. *Health and Disability System Review – Final Report – Pūrongo Whakamutunga*. Wellington: HDSR.

[49] Allen + Clarke. *GP Future Requirements Report*, October 2021.

[50] OECD. Health Data 2021. Health care resources, Physicians by categories. https://stats.oecd.org/Index.aspx?ThemeTreeId=9

[51] MBIE. *New Zealand Now: Healthcare Services*, December 2021.

into account current workforce shortages and unmet need in primary care (data which is collected) or unmet need in secondary care (data which is uncollected).

## A history of words but little action

In 2008 the SMO Commission, reporting on sustainable conditions of employment for senior doctors and dentists, made a list of recommendations to address the taxing workforce issues of the day, including to:

- Adopt strong clinical leadership
- Develop regional and national service planning to enable aligned SMO workforce planning
- Review and recommend medical student intakes at three-yearly intervals to align intakes with future service needs
- Identify core SMO workforce information and establish systematic ways of collecting, analysing and reporting that information to provide a common understanding of SMO workforce issues
- Streamline the registration process for IMGs.

A raft of similar worthy recommendations have emanated from a relay of medical workforce committees, taskforces, boards, etc since the start of the century (see box)

**Health Workforce Advisory Board (established 2019)**

**Doctors in Training Workforce Roundtable (2005)**

**SMO Commission (2008-09)**

**RMO Commission (2008)**

**Ministerial Taskforce Group on Clinical Leadership (2009)**

**The Medical Training Board (2007-2009)**

**The Clinical Training Agency (2009)**

**Health Workforce New Zealand (2009-2018)**

**Health Workforce Directorate in the Ministry of Health (2018 – 2022)**

The baton is now with Health Workforce Advisory Board a new Workforce Taskforce within Te Whatu Ora Health New Zealand…

# A response to the crisis: ASMS recommendations to government

**Key issues**

- **Failure to launch: repeating past health workforce strategy and policy recommendations, with little implementation**
- **Potential solutions can be unique to Aotearoa New Zealand, through mātauranga Māori and Te Tiriti o Waitangi lens**

| iGPS-Health priorities | ASMS recommendations for change: |
|---|---|
| 4 5 6 | **8. Grow capacity at undergraduate level**<br>a) Increase the numbers of doctors graduating from each Aotearoa New Zealand medical school to 300 by 2027 |
| 4 5 6 | **9. Strengthen postgraduate pathways**<br>a) Engage with specialist colleges, associations, responsible authorities, and unions to improve coordination, increase flexibility and provide certainty for employment prospects |
| 3 4 5 6 | **10. Sustain support for SMOs and IMGs**<br>a) Address immediate workforce shortages in the short-to-medium term through an international recruitment strategy<br>b) Build a retention strategy for later-career SMOs and IMGs |
| 1 2 3 4 5 6 | **11. Make cultural safety a priority for all health sector organisations**<br>a) Invest in the workforce and resourcing needs to build capacity in cultural safety, so that cultural loading is not an unintended outcome<br>b) Develop and implement cultural safety strategies that build on Te Tiriti o Waitangi, Hauora Māori, health equity, and anti-racism |
| 1 2 3 4 5 6 | **12. Approach health service design and delivery collectively, harnessing the clinical experience within the health workforce and engaging with communities**<br>a) That power is shared, recognising the diversity of skills and expertise within the health workforce, and the knowledge and experience of communities<br>b) That within health organisations, leadership is provided by workers with intimate knowledge of system operations and in relation to the vision and goals of the Pae Ora Act 2022 |

1 2 3 4 5 6

**13. Act to reduce the risk of future health policy failures**

a) Establish an independent Policy Costings Unit

b) Work with opposition parties to develop a cross-party political accord to enable evidence-based policies, including sustainable health and social investment, to be implemented over the longer term

# Developing a health workforce plan and actions

The health workforce takes up a least two-thirds of a health system's operational spending. The changing needs for health services, developing technology, the changes in the workforce itself, and the often-long time lags between policy decisions and actual results mean comprehensive health workforce planning is essential for ensuring an effective and sustainable health system.

Matching and forecasting the needs, demand and supply of health workers are complex in any context. No country in the world that has done it in a way that could be called "best practice". However, the WHO has outlined some lessons learned from the experiences of workforce planning in 10 countries and, while published in 2010, many of the lessons remain as relevant today. They include:[52]

- The choice of a strategy to assess the future health workforce is value-based and depends on what outcomes and service objectives policy-makers have set. The intended outcomes and objectives therefore must be clear and unambiguous.
- Assessing future health workforce needs is not only about projecting the numbers but embedding the effective policies on recruitment, education, distribution, retention, motivation and management. "There is little benefit educating adequate numbers of doctors and nurses, only to see them migrate to other countries because the labour market cannot integrate them, or because working conditions are not attractive enough."
- Sufficient and predictable funding must be available to invest in the workforce. "The benefits will soon be apparent in terms of better access to services, more efficient utilisation of resources and higher satisfaction of citizens."
- A workforce plan should not be regarded as a "one off' but a living document that is tested and revised as necessary.
- Planning must take into account the health workforce as a whole.
- Having an information base that provides valid, reliable, and up-to-date data to establish and monitor workforce plans is critical.
- The (ongoing) process must engage the main stakeholders.

Considering the above lessons and more recent international experiences in workforce planning and

[52] Dussault G, Buchan J, et al. *Assessing future health workforce needs*, WHO/European Observatory on Health Systems and Policies, 2010.

policy development for meeting medical workforce needs, and the current state of Aotearoa New Zealand's medical workforce, the following outlines a process and some key elements to be included in a national medical workforce plan.[53] [54] [55] [56]

## Get the data: A comprehensive assessment of current health need and medical workforce need

Data on which to develop a workforce plan is fundamental, including:

- A comprehensive population survey of unmet need for hospital and secondary care (including outpatient caseloads), including by age, gender, ethnicity and deprivation status, reported publicly. Without this, it is not possible to accurately assess workforce requirements.
- A comprehensive census of the medical workforce, supplemented by workforce-related data from health provider organisations, reported publicly. The Royal College of Physicians' census in the UK could be a model further developed and adapted for Aotearoa New Zealand's information needs. This would include questions on vacancies, time for non-clinical work (including training and education responsibilities), leave cover, rota gaps, job satisfaction, career intentions, etc.
- A gap analysis of workforce census data and unmet health need data to assess the current medical workforce capacity to meet current demand and to inform future medical workforce needs, including medical school intake requirements.
- Specialist forecasts by specialty based on recent entry and exit trends by age group, matched with forecast service capacity needs based on recent trends and taking into account the above assessment of the current SMO workforce capacity to meet current demand.

And all of the above must be routinely repeated as implementation of the plan progresses.

## Develop the plan and an implementation roadmap

Bring together all analyses, insights and directions revealed from workforce analysis, stakeholder engagement and demand modelling and develop strategies to work towards closing the identified gap between current workforce capacity and current health need.

Develop, in consultation with stakeholders, an applied and pragmatic implementation roadmap prioritising the agreed strategies. This plan should specify how the agreed actions will be achieved, proposed timeframes for execution and evaluation, and which stakeholders will be involved.

---

[53] Department of Health (Australia). *National Medical Workforce Strategy 2021-2031*, 2021.

[54] West M, Coia D. *Caring for Doctors Caring for Patients*, General Medical Council (UK), November 2019.

[55] Hamer B, Guilfoyle C. A proactive approach to building the healthcare workforce of the future, *Digital Pulse*, PWC Australia, 25 September 2019.

[56] Morris R, Smith M. *Demand for medical consultants and specialists to 2028 and the training pipeline to meet demand*, HSE – National Doctors Training & Planning, Dublin 2020.

Governance arrangements could include the establishment of time-limited working groups to advise on the implementation of specific actions.

Given the long lead times needed to effect change in most policy areas, work must start now.

Reports on progress must be published regularly.

# Key elements to consider in a medical workforce plan

## Rebalancing supply and distribution

There are hospital specialist and GP shortages, too few Māori doctors and, in primary care in particular, poor distribution of doctors across the country, which leads to an over-reliance on locums and IMGs (with poorer retention rates) to service some areas. The distribution of trainees across the specialties is also uneven, with some specialties more vulnerable than others in terms of the ratio of trainees to older specialists, as shown in Table 1.

### Immediate and longer-term actions are needed

To address current workforce shortages, urgent action is needed to improve retention across the board, discussed further below and, as a temporary measure, to increase the supply of IMGs. The latter is necessary to start to address mounting health service pressures and substantial unmet need, including the pandemic-related backlog, as well as to build the necessary capacity to train more doctors.

Te Whatu Ora Health New Zealand has accepted recommendations from the Planned Care Taskforce, established in May 2022 to find ways to tackle the growing waiting lists, including actions to improve monitoring and reporting, prioritising patients, outsourcing, improving theatre efficiency and creating "significant capacity for First Specialist Appointments by eliminating unnecessary follow-ups", and waiting-list targets. But there was no recommendation on staffing. As the Health Workforce Advisory Board has commented prior to the release of the recommendations, such actions alone are not solutions "unless urgent health workforce issues are attended to in the short, medium and longer terms". [57]

### Building the specialist workforce in the short term through increasing IMGs requires an effective and well-resourced international recruitment strategy

For the longer term, Aotearoa New Zealand's supply of domestically trained doctors must increase substantially and urgently. Currently around 560 medical students graduate each year. However, ASMS projections indicate specialist workforce shortages of at least 20% will continue through to 2031 and beyond, based on current workforce and service use trends (see above). This suggests

[57] Health Workforce Advisory Board. *Annual Report to the Minister of Health*, January 2022

medical school intakes need be increased by well above 20% to address future hospital specialist shortages and reduce dependency on IMGs - not taking into account additional numbers needed to address GP shortages, and the attrition rates of an ageing workforce over the next decade.

Broadly, this supports one assessment of a required additional intake of at least 200 students per year. [58] That would put Aotearoa New Zealand on a par with Australia's current graduate numbers per capita but would still be well below that of the highest group of OECD countries.

Affirmative action and pro-equity pathways to create a health workforce that reflects Aotearoa New Zealand's diverse communities are showing signs of good progress, especially for Māori, and these must continue to be prioritised as overall medical school intakes increase. Further, there is scope for medical colleges to align their own selection policies to support the strategic direction of a medical workforce that reflects Aotearoa New Zealand.

Increases in medical school intakes on such a scale will need to happen incrementally over several years to build the requisite capacity of both medical schools and health services to provide education and training.

Regular audit and review, based on the data collection and reporting discussed above, would inform any adjustments to be made to supply needs as necessary. Monitoring the increasing number of trainees against the number of senior doctor supervisors will be critical to ensure training bottlenecks are avoided.

This will also inform decisions about the distribution of training places, and policy interventions must be developed to promote specialties in that are especially vulnerable to under-supply, including providing better information for students and newly-qualified doctors to make informed career decisions.

To improve the geographic distribution of the workforce, the plan should take a multi-pronged approach to encouraging doctors to work in the regions, adding to current initiatives such as the Voluntary Bonding Scheme. For example, a scoping review has concluded that rural background and rural exposure with participation in a rural-focused medical school were the main determinant factors of recruitment and retention of the rural and remote medical workforce. Educational strategies - ie, student selection, rural learning experience, and integrative rural-focus curriculum in medical schools - successfully improve rural and remote medical workforce recruitment and retention.[59]

Other approaches include investing more in regional training hubs, improved tele-health technology, networking, increasing rural training placements, ensuring access to locums and continuing professional development and educational materials, improving support for settling in rural settings,

[58] Ellis F. Plan aims for more doctors, *Otago Daily Times*, 10 August 2022.

[59] Noya F, Carr S, et al. Strategies to Facilitate Improved Recruitment, Development, and Retention of the Rural and Remote Medical Workforce: A Scoping Review, *Int J Health Policy Manag* 2021, x(x), 1–16

including assisting in finding housing for new recruits and their whānau, and employment for a doctor's partner. [60]

The workforce implementation plan should include regular analysis of Aotearoa New Zealand's domestic and international workforce supply to inform the settings for migration of IMGs to fill workforce gaps.

## Improving retention

Improving retention rates of Aotearoa New Zealand's current and future senior doctor workforce has never been more pressing. Yet, outside of the work done by ASMS, there is a dearth of information to inform effective retention strategies.

A Medical Council-commissioned survey of a small number of IMGs (51) requesting a Certificate of Good Standing and who were leaving, 41% of respondents had only intended to stay in Aotearoa New Zealand for a short time; 24% left for family reasons, 22% left to take up other professional opportunities or higher training, and 16% left for higher remuneration.[61]

In a further MCNZ survey of *all* doctors requesting a Certificate of Good Standing and who had indicated that they were leaving Aotearoa New Zealand, most respondents (182 doctors) identified multiply reasons for leaving, the most common being:[62]

- undertaking further training
- increased remuneration
- family reasons
- improved working conditions
- locum opportunities.

In a national survey of DHB-employed ASMS members (IMGs and Aotearoa New Zealand-trained) on their career intentions within the next five years, the top reasons cited for not wishing to continue with DHB-based employment (24% of respondents), were age, disillusionment with DHB management and the direction of the public health system, and exhaustion and pressure of work.

The top themes cited as possible inducements to remain were provision of flexible working hours or part time work, better management culture and less bureaucracy, and better resourcing and staffing levels. [63]

Among a relatively small number of those intending to leave the country, higher remuneration was the most cited reason, followed by career opportunities and family reasons.

---

[60] RANZCP. Rural Psychiatry. Position Statement 65, February 2022. https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/rural-psychiatry

[61] MCNZ (2010). Helping international medical graduates integrate. *Medical Council News*, Issue 50, December 2010.

[62] MCNZ (2011). *Doctors leaving New Zealand: Analysis of Online Survey Results*, MCNZ, September 2011.

[63] Chambers C. Future intentions of the New Zealand DHB senior medical workforce, *Health Dialogue* Issue 13, July 2017. https://www.asms.org.nz/wp-content/uploads/2022/05/Future-intentions-of-the-NZ-DHB-based-senior-medical-workforce.pdf

In a repeat survey conducted by ASMS in 2022, but including non-DHB-employed members, a similar proportion of respondents (25%) indicated they intended to leave their current employment within the next five years. Detailed results, including reasons for intending to leave, are currently be collated.

While it is recognised that health service employers may not be able to influence some factors concerning staff turnover (eg, family reasons), there are many factors that they *can* influence. The medical workforce literature highlights the need for health service organisations to consider the reputation of their organisation as an employer and as a place to work, to create a climate that will attract and retain staff.[64] [65]

A major report on health professional mobility in Europe identifies three key factors that influence whether staff will stay or go:[66]

- employment quality
- work quality
- organisational quality.

Employment quality relates not just to pay but also to terms and conditions, such as opportunities for flexible working arrangements and conditions that enable a reasonable work-life balance.

Social benefits are also an important part of employment quality. Contractual relationships that allow for pension schemes, flexible retirement policies, childcare provisions, and so on have shown to be factors influencing job quality.

Work quality includes several variables around inappropriate or unsafe work. For example, high levels of administrative burden have been shown to have a negative effect on retention. In addition, many studies report negative effects of work-related stress in health care, particularly from high workload. Studies show that the consequences of continued high levels of stress for health professionals, including doctors, include reduced efficiency, higher error rates and higher staff turnover.

In relation to organisational quality, the literature on retention has a particular emphasis on the relationship between leadership and staff satisfaction. Dissatisfaction with management styles has been shown to be a major driver in job dissatisfaction. On the one hand, doctors have reported dissatisfaction with their level of influence over their work, the perception of not being heard, disconnection between management and clinical work, lack of shared decision-making and lack of recognition. On the other hand, participation in decision-making processes has been found to enhance job satisfaction.[67]

---

[64] Zurn P, J-C Dumont. *Health Workforce and International Migration: Can New Zealand Compete?* OECD Health Working Paper: OECD, 2008.

[65] Addicott R, Maguire D, et al. *Workforce Planning in the NHS*, The King's Fund, April 2015.

[66] Buchan J, Wismar M, et al (eds). *Health Professional Mobility in a Changing Europe: Volume II*, European Observatory on Health Systems and Policies, World Health Organisation, 2014.

[67] ASMS. International medical migration: How can New Zealand compete as specialist shortages intensify? *Research Brief*, Issue 6, 2017.

For IMGs, preliminary results from the latest ASMS survey of members on their career intentions identified a lack of support on arrival on a wide range of issues, including lack of information on the heath system, cultural safety and help with housing. Only 43% indicated they had a formal employment induction when they arrived. As many respondents had been in Aotearoa New Zealand for more than 10 years, further investigation is needed on whether support for IMGs has improved.

## Building the generalist capability of the medical workforce

While over the past decades there has been an increasing trend towards centralised, sub-specialised care internationally, a country the size of Aotearoa New Zealand needs a greater emphasis on "generalist specialists" – that is, rural generalists and general specialists, such as general surgeons and physicians who retain a broad scope of practice.

As the population ages, patients are presenting with multiple conditions that need the care of several specialists. This can mean patients and whānau often find themselves being shuttled from one specialist to the next, with no one taking overall responsibility for their care. There is also a real risk that important aspects of patients' care are neglected – for example their mental health needs or basic requirements such as diet, hydration, and urinary function. These aspects of care are vital to patients' recovery, mobility while in hospital, and to a timely discharge.[68] [69]

Generalists have an important role in helping to co-ordinate input from a range of professionals and to ensure that patients' wider needs are met. One of the key principles of generalism as "seeing the person as a whole and in the context of their family and wider social environment". While patient-centred care is a feature of all good medical care, the value of a generalist is the ability to provide holistic care. [70]

A generalist medical workforce is especially important for rural communities, which face challenges receiving the same access to medical care as people living in urban areas.[71]

In Aotearoa New Zealand, rural communities have traditionally been served by a mix of rural general practitioners, rural nurses and rural hospital doctors. The New Zealand Rural Hospital Summit in 2020 highlighted the rural workforce crisis and the urgent need for a rural health workforce plan to build a workforce able to offer rural people equitable access to health services. It has also called for the development of a 10-year rural health strategy in partnership with iwi and rural communities to provide leadership, accountability, and a robust basis for service commissioning.[72] These proposals should be actioned to set a clear future direction that will enable rural health workforces, including

---

**[68] Dixon A (opinion). Do we need more generalists in our hospitals?, *BMJ,* 17 October 2011.** https://blogs.bmj.com/bmj/2011/10/17/anna-dixon-do-we-need-more-generalists-in-our-hospitals/

[69] ASMS. *Taking the temperature of the public hospital specialist workforce*, August 2014.

[70] Independent Commission for the RCGP and the Health Foundation. *Guiding Patients Through Complexity: Modern Medical Generalism,* October 2011.

[71] Larkins, S, Evans R. Greater support for generalism in rural and regional Australia. *Australian Family Physician* 43: 487-490, 2014.

[72] New Zealand Rural Hospital Network (NZRHN) website. Rural Hospital Summit 2020 https://nzrhn.co.nz/2020/10/rural-hospital-summit-2020-2/

GPs, rural hospital medicine (RHM) specialists and other medical specialists, to work together to achieve desired outcomes for rural populations.[73]

In addition, the current number of RHM specialists is insufficient to address the serious shortages in many rural communities. As part of the urgent need to increase medical school intakes generally, targeted funding is needed to ensure the RHM training programme continues to grow.

Providing opportunities for doctors to consider generalist and rural career options, along with ongoing support for generalists in practice, will foster a more sustainable and flexible medical workforce that can provide both generalist specialist and subspecialist care to patients and whānau closer to home.

However, developing this workforce effectively has been stymied by a lack of research on rural health and rural hospital work. This must be addressed.

## Reforming training pathways

Many of today's medical training issues have been identified in earlier reports, such as the former Medical Training Board's (MTB) 2009 report Foundations of Excellence [74] and the MCNZ's 2011 discussion document on prevocational training.[75] Many hospital-based speciality training programmes are coordinated through trans-Tasman medical colleges, and the Australian Medical Workforce Strategy 2021-2031 has identified issues in the coordination and regulation of training pathways, making a range of recommendations for reform.[76]

Since then some improvements have been made, particularly in prevocational training, but much remains to be done on some long-standing issues.

Trainees will experience a range of challenges on the pathway to vocational registration as a specialist. Issues such as heavy workloads, the extent of feedback provided by clinical supervisors, a culture that negatively impacts on wellbeing, and experiences of bullying, harassment and discrimination have been well documented.

A recent survey of resident medical officers (RMOs) on fixing workforce shortages highlighted a desire for more flexible work and training arrangements and better opportunities to take leave as key issues behind remuneration. While nearly 90% of respondents indicated they intended to complete their vocational training with Te Whatu Ora Health New Zealand, 71% called for a guarantee of employment on completion of their training. [77]

[73] ASMS. Rural health at a crossroads: tailoring local services for diverse communities, *Research Brief*, Issue 28, 2021.

[74] MTB. *Foundations of Excellence: Building Infrastructure for Medical Education and Training,* Report of the Medical Training Board, August 2009

[75] MCNZ. *Prevocational Training Requirements for Doctors in New Zealand*: a discussion paper on options for an enhanced training framework, May 2011.

[76] Department of Health (Australia). *National Medical Workforce Strategy 2021-2031*, 2021.

[77] RDA. RMO *Shortages: Fixing medical workforce shortages*, RDA, August 2022.

In the medical apprenticeship model, achieving a balance between training and service is difficult. Service requirements and budgets drive the number and distribution of registrar training places rather than the number of doctors needed as specialists. Coordination of training and service provision is challenged by specialist medical colleges and employers having different processes, roles, responsibilities and timing for selection and employment.

A top priority for improving doctors' training experience and to ensure an adequate supply and mix of specialists into the future must be the establishment of a comprehensive workforce data strategy and ongoing modelling to determine future needs.

The Australian National Medical Workforce Strategy recommends using supply and demand modelling to determine the numbers of trainees and supervisors needed for each specialty, and applying this data to inform training pathways. In Aotearoa NZ, this information could be collated to generate a 'virtual pool of training places', which would influence the number training positions for various specialties, as well as establishing a process to distribute trainees to where they are needed most, such as regional and rural areas, and specialities experiencing higher precarity. Once there is certainty on numbers and distribution of trainees and supervisors, the pool can be extended to the whole of the training pathway, including at the prevocational level.[78]

The pool and supporting processes would require co-design with specialist medical colleges, speciality associations, medical unions, employers, the Medical Council and other stakeholders to ensure its effectiveness. Implementation would need to be staged given its complexity.

In 2009 the Medical Training Board report on building infrastructure for medical education and training concluded:

- the health care system needs greater integration of medical education and training across the continuum of learning, from entry to medical school to completion of vocational training, with a supportive structure that allows for flexibility to recognise the variety of ways that doctors move through the learning process
- the current systems of apprentice training and experiential learning for doctors-in-training need enhancing by consistent management with oversight of the educational aspects of clinical placements
- improvements in accountability for, and monitoring of, funding relating to postgraduate education and training funding are needed.

To address these issues the MTB recommended that "a new body is established with the capacity to coordinate medical education and training across the entire continuum of learning and govern the transition from the current system". The new body would also lead work to, among other things:

- increase support for clinical teachers, including incentivising quality training
- increase the range of training institutions that are able to be involved in training doctors (eg, private hospitals and community settings)
- ensure system-wide integration of education and training

[78] Department of Health (Australia). *National Medical Workforce Strategy 2021-2031*, 2021.

- develop a national information system for medical education and training
- enhance links with other sector groups including the MCNZ, medical colleges, district health services, medical schools, and professional groups
- provide a basis for coordination in other areas of postgraduate education and training, including nursing, midwifery, and allied health

Since then several medical training and medical workforce bodies have come and gone, most notably Health Workforce New Zealand. The recommendations made by the MTB in 2009 were hindered by lack of resources, lack of data, an absence of research and the many immediate challenges of a fragmented health system remain largely unrealised.

These proposals must now be included on the work programme of the newly-formed "Workforce Taskforce" within Te Whatu Ora Health New Zealand, and underpin longer-term strategic policy development by the Ministry of Health. These initiatives must be aided by significantly better investment in data, research, and support personnel to avoid a repeat of past failures.

## Embedding cultural safety

While medical schools have made sustained efforts to ensure their undergraduate medical education programmes equips doctors to practise in a culturally safe way, the extent to which prevocational and vocational training programmes focus on cultural safety, Hauora Māori, Te Tiriti o Waitangi and anit-racism is variable. Māori doctors interviewed for one report on cultural safety expressed disappointment that prevocational training did not align with the extent to which their undergraduate training had embedded cultural safety.[79]

To the extent that health professionals engage with patients with positive intent, there is evidence that misperception and lack of connection between patients from non-dominant ethnic groups and medical professionals is not uncommon. Studies have consistently demonstrated that doctors, for example, treat Māori differently from non-Māori because of a lack of cultural awareness, conscious or unconscious biases, and institutional racism.[80] [81] [82] This contributes to Māori having the poorest health outcomes of any ethnic group in Aotearoa NZ.

The MCNZ has sought to improve integration of cultural and clinical competence and safety through recertification and continuing professional development requirements. This includes Council-approved programmes which must cover audit, peer review and team-based assessments to verify that individual practitioners practise competently and have an understanding and respect of cultural

[79] Allen + Clarke 2020, *Baseline Data Capture: Cultural Safety, Partnership and Health Equity Initiatives,* Medical Council of New Zealand and Te Ohu Rata o Aotearoa, Wellington.

[80] Harris RB, McCormack D, Stanley J. Experience of racism and associations with unmet need and healthcare satisfaction: the 2011/12 adult NZ Health Survey. *Aust NZ J Pub Health*. 2019; 43(1):75-80. https://onlinelibrary.wiley.com/doi/full/10.1111/1753-6405.12835

[81] Curtis E, Paine S-J, Jiang Y, Jones P, Tomash I, et al. Examining emergency department inequities in Aotearoa New Zealand: findings from a national retrospective observational study examining Indigenous emergency care outcomes. *Emerg Med Australasia*. 2022; 34(1): 16-23. https://onlinelibrary.wiley.com/doi/full/10.1111/1742-6723.13876

[82] Jansen P, Bacal K, Buetow S. A comparison of Māori and non-Māori experiences of general practice. *NZ Med J* 2011; 124(1330):24-9. https://journal.nzma.org.nz/journal-articles/a-comparison-of-maori-and-non-maori-experiences-of-general-practice

competence, cultural safety, and the determinants of Hauora Māori. From 1 July 2022, cultural safety and health equity must be embedded across recertification programmes for vocationally trained doctors.[83]

The literature underscores that development of cultural competence and safety as an iterative process. Information components are generally well-received and can be developed over a relatively short period of time but changing attitudes and unpacking one's own biases requires gradual, progressive engagement and effort – and importantly, making time for self-reflection. While cultural competency can be understood as understanding the practices and cultural protocols of the other, cultural safety is understanding oneself.

Researchers have found that encouraging critical thinking and moral reasoning more generally helps to reduce bias. A study examining how doctors learn in the workplace suggests the kinds of endeavours needed for developing cultural competence requires protected time, away from the direct demands of patient care, to undertake "deliberate practice" – a focused effort to reflect and develop performance aspects that need improvement. Hence the importance of full access to time for continuing education.[84]

It is critical that the workplace environment is conducive to cultural safety. The commonly reported time-pressured work environments that leave little time for critical reflection must be high on the list for attention.

The first priority is to sustain a group climate for learning. Management can contribute by initiating work procedures that facilitate these knowledge exchanges, and by identifying recurrent organisational problems in order to improve practices and free up precious time for learning. Where organisations seek to integrate Te Ao Māori (the Māori world) into workplace practices, it is essential that this doesn't place additional expectation or cultural load on Māori to educate their non-Māori colleagues on Te Tiriti o Waitangi, anti-racism, translation tasks or tikanga such as karakia and pōwhiri.

The important role for Government is to have policies and strategies in place that require public health and social organisations to make genuine cultural safety, Te Tiriti o Waitangi, Hauora Māori and anti-racism a priority – that is, not a tick-box exercise but engaging the hearts and minds of the entire organisation – and to ensure they are resourced to do that.

The Government also needs to improve the collection, monitoring, analysis and reporting of quality ethnicity data – both from an organisational performance and workforce perspective. This is identified as a priority in the *Whakamaua: Māori Health Action Plan 2020–2025*. [85]

In line with the requirements of the Pae Ora Act, performance indicators should require health care organisations to, among other things, demonstrate:

---

[83] MCNZ strengthening recertification. https://www.mcnz.org.nz/assets/Publications/Booklets/f7d4bc7fff/Strengthened-recertification-requirements-for-vocationally-registered-doctors-November-2019.pdf

[84] [84] . Wiel MWJ, Bossche P, et al. 'Exploring deliberate practice in medicine: how do physicians learn in the workplace?' *Adv in Health Sci Educ*. 2011; 16: 81–95.

[85] Ministry of Health. *Whakamaua: Māori Health Action Plan 2020–2025*. Wellington: Ministry of Health, July 2020.

- How they are responding to Treaty-based requirements to deliver effective and equitable healthcare to Māori, and ensuring that these requirements are reflected in organisational planning and accountability documents.
- Where they are incorporating Māori models of care, or mātauranga Māori (Māori knowledge), as appropriate.
- The extent to which Māori are included in governance and decision-making.
- The extent to which they are identifying and addressing structures and processes that limit Māori health development.
- A commitment to supporting a strong Māori health workforce.
- Evidence of transformation with respect to, cultural safety

A Medical Council/Te ORA report on cultural safety in vocational training, made the following recommendations to colleges.[86]

- The development of comprehensive policy documentation around the recruitment and retention of Māori trainees is imperative.
- College governance structures should enhance Māori participation in their complete range of activities.
- All college trainees and fellows should receive training in cultural competence and cultural safety as part of continuing professional development programmes. Training for staff is also highly recommended.
- Formal structures within colleges that bring Māori trainees together and support Māori trainees are recommended.
- Colleges should identify ways to enhance the training environment to ensure cultural safety of their trainees.
- Collaboration and information sharing between colleges in the pursuit of a robust Māori workforce and excellent training around cultural safety and health equity is strongly recommended.

## Supporting strong collective leadership

*In this time of workforce shortages and steep growth in service demand … people are already working hard, so the greatest gains will come from working smarter. Innovation is needed, and the most creative ideas are usually generated closest to the service delivery level. SMOs and other health professionals need to have the opportunity to generate and test new ideas, the enthusiasm to want to do so, and managerial colleagues who will support them in this.*

- New Zealand SMO Commission, 2009[87]

[86] Carter M, Potiki M, Haggie H, Tipene-Leach D. *Cultural safety within vocational medical training*. Report of Te ORA and the Council of Medical Colleges, May, 2021

[87] Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by District Health Boards. 2009. *Senior Doctors in New Zealand: Securing the future*. Wellington: Ministry of Health.

*Quite simply, the reforms we need are only likely to be successful if clinically led.*

– Professor Des Gorman, Executive Chair, HWNZ, 2011[88]

For effective collective leadership, including distributed clinical leadership, all leaders in formal roles must understand what is needed to nurture a caring, collaborative culture. They must also pay conscious, deliberate attention to creating the conditions in which responsibility, power, authority, and decision-making is distributed within and throughout an organisation rather than at the top of a hierarchy. For collective, distributed leadership, all staff must be engaged.

Leaders must emphasise collaboration as a key principle of success and embrace their organisation as learning environments where the capabilities of individuals and teams are continually enhanced. Organisations must span their boundaries and work together, rather than develop leadership within silos.

Distributed clinical leadership and broader collective leadership must be prioritised at the highest level of the system: by elected governments and government officials. Ministry and agency staff are essential in supporting collective leadership approaches within long-term health strategy well beyond the length of time that ministers hold office.[89]

A directive from the Minister of Health to Districts that collective leadership must be supported and developed as fundamental driver for improved care would be a positive start.

> *Paradoxically, it is sometimes necessary to use command-and-control to move the organisation away from command-and-control.*
>
> - The King's Fund[90]

The King's Fund report advocates for "Every board [to] ensure that it understands the leadership capabilities required in future, how these are going to be developed and acquired, and what organisational and leadership interventions will enable them to be delivered". Boards must then assure themselves, Ministers, and the public – through regular monitoring reports – that the collective leadership strategy for their organisation is implemented as "the challenges that face health care organisations are too great and too many for leadership to be left to chance or to piecemeal approaches". [91]

Monitoring the progress of collective leadership strategy must also recognise the long timeframe necessary to bring about the required cultural change, with all the complexity involved.

Organisations can support doctors in leadership roles by improving the culture of leadership at all levels. Good organisational leadership depends on formal leaders who are effective communicators and who can listen well. In turn, this can help enable staff at all levels to lead effectively, recognising

[88] Gorman, D. The disposition and mobility of medical practitioners in New Zealand, *NZMJ* 4, Vol 124 No 1330; March 2011.

[89] Ham C. How Can Improving Leadership Help Transform the NHS? (blog), The King's Fund, 19 May 2014. https://www.kingsfund.org.uk/blog/2014/05/how-can-improving-leadership-help-transform-nhs

[90] Eckert R, West M, Altman D, et al. *Delivering a collective leadership strategy for health care*, The King's Fund, 2014.

[91] West M, Eckert R, Steward K, et al. *Developing collective leadership for health care*, The King's Fund, May 2014

leadership in all its forms, and providing support for individual doctors to transition into leadership roles.[92]

Lack of resources, including under-investment in staffing, is a commonly cited barrier to implementing collective leadership and specifically distributed clinical leadership. Adequate funding is critical to enable health districts to employ sufficient staff to engage in bringing about what amounts to fundamental changes in organisational culture.

**Collective leadership and cultural safety**

The concept of collective leadership in Aotearoa New Zealand must also recognise that while it requires managers to relinquish some of their power to clinicians, a comparable dynamic exists in the relationship between clinicians and patients and whanau (understanding the importance of whanau for Māori patients), and a similar power shift is needed. To help address our stark health inequities, collective leadership must incorporate the dimensions of cultural safety, which strongly emphasises the importance of extending patient involvement to whanau. Those dimensions are:

(1) transfer of power from provider to recipient of care;

(2) attitude change in the provider;

(3) the recipient determines if the care is safe; and

(4) development of skill and knowledge to challenge and change harmful institutional practices.[93]

## Providing more flexible working arrangements

Improving retention among older specialists is increasingly critical as many are nearing the traditional retirement age, raising concerns that this will exacerbate existing shortages. Strategies identified for improving retention include intervention to reduce stress, changing work roles, introducing more part-time and job-share positions, and more flexibility in work hours.[94]

In the 2017 national survey of ASMS members on their career intentions, which found 24% of respondents intended to leave DHB employment within five years, the most commonly cited possible inducement to remain was provision of flexible working hours or part time work.

"The number of women in the medical workforce is growing in Aotearoa NZ and globally: in 2000, 19% of the medical specialist workforce identified as female; by 2021 this had more than doubled to 41%. MCNZ and Census data show that women tend to spend fewer hours in paid employment, due to the demands of care and household work." [95] [96]

[92] General Medical Council (UK). *The state of medical education and practice in the UK*, 2019

[93] Simmonds S, Carter M, et al. *Baseline Data Capture: Cultural Safety, Partnership and Health Equity Initiatives*, Medical Council of New Zealand and Te Ohu Rata o Aotearoa, Wellington, October 2020.

[94] Ineson S. *Retention of doctors in their third age.* Wellington: Health Workforce New Zealand, May 2011.

[95] MCNZ. Medical Workforce Surveys.

[96] ASMS Salary Survey 2021.

As these trends continue, the projected specialist headcounts required to ensure a viable and secure workforce will need to be adjusted upwards to achieve the same number of full-time equivalents.

In addition, a growing desire for a better work-life balance across the workforce is likely to have a similar impact on supply over the next decade. One Australian survey indicated 81% of hospital doctors want greater access to flexible working arrangements to allow them to spend more time with family and friends, or continue further formal training. The work-life balance factor is now a common drawcard in advertisements for medical positions.[97] [98]

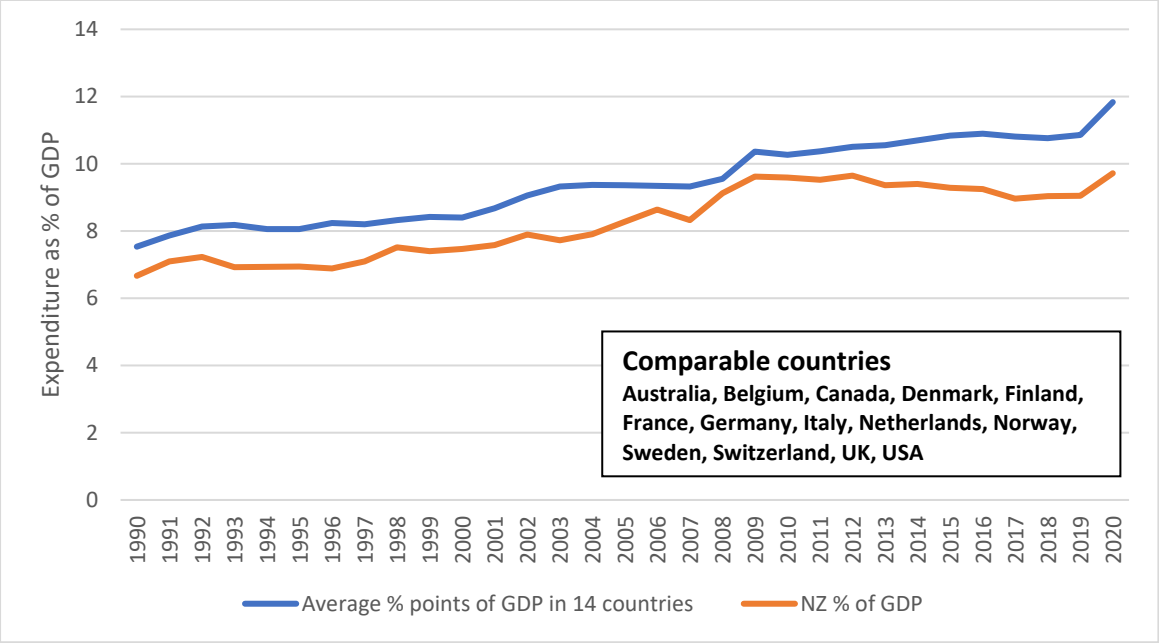
# Matching funding to health service needs

*Overall, the case for investing in human resources for health has never been stronger, with the potential for a positive impact going far beyond the health sector*

- Cometto et al, 2016[99]

Aotearoa New Zealand's total (public and private) health expenditure, measured as a proportion of GDP, has remained well below other comparable countries for many years (Figure 9).

**Figure 9: Total health expenditure as a percentage of GDP – Aotearoa New Zealand and the average of 14 comparable countries, 1990-2020**




Source OECD Health Data 2022

[97] ASMS. Demographic and attitudinal change in the New Zealand specialist workforce. ASMS *Research Brief*, Issue 5, 2016.

[98] Australian Medical Association. AMA Work-Life Flexibility Survey 19 June – 13 July 2007. Kingston, ACT: AMA, April 2008.

[99] Cometto G, Campbell J. *Human Resources for Health* (2016) 14:51

Responses to the Covid-19 pandemic has driven spending upwards globally since 2020. In terms of expenditure as a percentage of GDP, Aotearoa New Zealand would have needed to be spending an additional $6.7 billion in 2020 to equal the average of the 14 comparable countries. A similar gap exists with health spending trends per capita.

## Aotearoa's high health needs but poor access to care

Caution is needed in reaching conclusions from health spending comparisons across countries as they lack context. However, to add some perspective, while Aotearoa New Zealand ranks highly on quality and efficiency, it compares poorly on measures of equity, access and outcomes, and health status measures[100] indicate our health needs are relatively high.

In an assessment of universal health coverage by an international Global Burden of Disease study Aotearoa New Zealand ranks second-to-bottom of 15 comparable countries. Universal health coverage is described as "all people receiving the health services they need, of high quality, without experiencing financial hardship". Effective coverage indicators were transformed to values on a scale of 0–100. Aotearoa New Zealand scored 83 points, one ahead of bottom-placed USA.

Compared to those same countries, our health needs are mostly at the high end in a range of common health status indicators, and we are ranked last on number of people working in health services, residential care and social work. We have one of the lowest numbers of total hospital beds per capita, as well as having one of the lowest numbers of psychiatric beds and intensive care unit (ICU) beds in the OECD.

New Zealanders have relatively poor access to publicly funded new medicines, and we're at the lower end for cancer survival for six of seven sites of cancer among seven high-income countries.

All of which indicates the substantial gap in heath spending between Aotearoa New Zealand and other comparable countries mirrors a similar gap in unmet health need and the capacity to respond.

## The economic burden of ill health

Further, poor health and unmet health need impact badly on the economy. The cost of ill health due to lost productivity was estimated by Treasury to be between $4.127 billion to $11.563 billion in 2004/05. This is 2.7% to 7.6% of GDP (about $9.8 billion to $27.5 billion today) with the large range due to the different methods and assumptions used.[101]

A separate Treasury report on the cost of long-term illness "clearly identified that long-term conditions are especially costly and are a source of significant economic burden on society. This burden is not just restricted to the health system and direct health costs. At a rough approximation, indirect costs (such as lost productivity) will equal the direct [health service] costs of a given

[100] Including infant mortality; premature mortality; mortality from ischemic heart disease, stroke and cancer; suicides; prevalence of obesity and diabetes; cancer incidence; anxiety disorders. Source OECD health status indicators and Global Burden of Disease Study 2019.

[101] Holt H. *The Cost of Ill Health*. New Zealand Treasury Working Paper 10/04, Wellington: NZ Treasury, November 2010.

condition."[102] In other words, if needed health care is not provided, or is delayed, the costs are substantial and accumulate.

# Investing in health systems for economic gains

*The size and nature of the health system … are likely to have profound direct implications for the performance of the economy as a whole*

- Cylus et al, 2018 [103]

Good health is a major contributor to productivity and prosperity, and health systems are not a drain on resources but an investment in health and wealth – that is, in the health of the population and in economic growth.[104] [105]

The health sector has an economy, it makes an economic footprint, and it has a labour market dynamic of its own. It employs people, builds skills through education and training, creates infrastructure and facilities, purchases supplies, and delivers communications and logistics. Health systems need a range of services and products, creating business for local companies. As the health sector expands, so does its impact on the economy, including increasing local wealth as employees who live locally often spend locally, which helps to build the social and economic resilience of the community. [106] [107]

A major study covering 25 European Union countries evaluating the economic effects of different types of government spending found that health spending had a fiscal multiplier of 4.3 (the extra income generated in the economy for each $1 dollar of government spending). [108] [109]

As the WHO's High-Level Commission on Health Employment and Economic Growth noted:

"There is now an urgent need to move away from the notion of health and health workers as purely an expenditure to be contained. To the extent that resources are wisely spent, investing in health is

[102] Ministry of Health. *Report on New Zealand Cost-of-Illness Studies on Long-Term Conditions*. Wellington: Ministry of Health, 2009.

[103] Cylus J, Permanand G, Smith PC. 2018. *Policy brief. Making the economic case for investing in health systems: What is the evidence that health systems advance economic and fiscal objectives?* Copenhagen: WHO Regional Office for Europe.

[104] Figueras J, McKee M (eds). *Health Systems, Health, Wealth and Societal Well-being:* Assessing the case for investing in health systems, European Observatory on Health Systems and Policies, WHO, 2012.

[105] Thomas C, Jung C, Patel P, et al. *Health and prosperity: Introducing the Commission on Health and Prosperity*, IPPR, 2022.

[106] Horton R, Araujo EC, Bhorat H, et al. *Final report of the expert group to the High-Level Commission on Health Employment and Economic Growth.* Switzerland: World Health Organisation, 2016.

[107] Ministry of Health. *The cost and value of employment in the health and disability sector*. Wellington: Ministry of Health, 2020.

[108] Reeves A, Basu S, McKee M, et al. Does investment in the health sector promote or inhibit economic growth? *Globalization and Health* 2013;9:43.

[109] Stuckler D, Reeves A, McKee M. Social and economic multipliers: What they are and why they are important for health policy in Europe**,** *Scandinavian Journal of Public Health,* 2017; 45(Suppl 18): 17–21

a productive investment. In addition to rights-based arguments for health and health equity, we should also view the health workforce as an opportunity to create decent jobs and accelerate sustainable social and economic development – critically important returns to society." [110]

## Investment Check

Health Minister Andrew Little claims the Government has increased health funding by 45% since it has been in office.[1] However, a basic analysis of the Government's health funding since its first Budget of 2018 gives a vastly different picture.

**Operational investment**
The Vote Health operational Budget for 2022/23, excluding Covid-related funding ($21.39 billion), was 32.2% more than actual expenditure in 2017/18 ($16.18 billion).

In our analysis, actual operational expenditure for 2017/18 is compared with budgeted operational expenditure for 2022/23, excluding Covid-related funding, and adjusted for CPI inflation, public health sector wage growth, and demographic changes. It also takes into account historical cost pressures (DHB deficits previously covered by the Crown) which were front-loaded into the 2022/23 health budget.

Wage growth and CPI-based inflation from June 2018 to June 2022 were calculated using Statistics NZ's public health sector Labour Cost Index and CPI-based inflation, assuming wages made up 66% of total spending and inflation 34% of the total. Demographic calculations were based on the Ministry of Health's estimated demographic adjustments.

Owing to the uncertainties in forecasting wage/inflation/demographic cost pressures for 2022/23, we have used the cost-pressure estimates stated in the 2022/23 Health Vote to calculate total cost pressures for the full period June 2018 to June 2023.

While this is a crude analysis, it is if anything a conservative indicator of how frontline services have been affected. It does not take into account the ongoing costs of restructuring, or the resources needed for addressing patient backlogs (both of which are absorbed in operational funding)[2]. See the Appendix for a detailed breakdown of the figures.

1. Radio NZ. Morning Report, 18 October 2022. https://www.rnz.co.nz/news/national/476874/hospital-wait-time-issues-are-systemic-say-healthcare-specialists
2. Sources:
Treasury. Estimates and Appropriations: Vote Health, 2021 and 2022.
Statistics NZ. Labour Cost Index; Population statistics; CPI trends
Ministry of Health. Demographic Forecast Model, updated 1 April 2021 (unpublished).

[110] High-Level Commission on Health Employment and Economic Growth. *Working for health and growth: investing in the health workforce*, WHO 2016.

# Ensuring policies are implemented

There are countless examples, here and internationally, of government policies not being fully implemented, or not implemented at all in any meaningful way. In Aotearoa New Zealand's health sector, initiatives in health workforce development, clinical leadership, integrated care and "health equity", all of which have been discussed and agreed to by successive governments and are still being talked about. Many of the policy intentions of the New Zealand Health Strategy of 2000 are echoed in the recommendations of the Health and Disability System Review published 20 years later.[111] Few working or receiving clinical services in mental health would have been surprised by the findings of the Mental Health and Addiction (MHA) Inquiry of 2018 that the MHA system "has not shifted" over many years, despite stated intentions to do so in earlier strategies. It concluded that "a fundamental disconnect exists between stated strategic direction, funding and operational policy and ultimately service delivery".[112]

The literature on the policy-implementation gap, or 'policy failure', identifies at least four broad contributors: overly optimistic assertions; implementation at the coalface; inadequate collaborative policymaking; and the vagaries of the political cycle.[113] [114]

**Over-optimism:** Political party policy-makers under-estimate the complexity of the delivery challenges and often lack the evidence base (insufficient objective, accurate and timely information on costs, timescales, benefits and risks).

**The local context:** In complex systems an intervention that is successful in one location does not necessarily deliver the same results elsewhere. And those operating at higher levels cannot succeed without having some grasp of what actually happens on the ground.

**Inadequate collaborative policymaking:** Policy has tended to be developed in silos, leading to poor implementation. Good policy design requires continuous collaboration with a range of stakeholders at different levels as well as engagement with local communities and the people who a critical to implementing the policy on the front line.

**Vagaries of the political cycle – short-termism:** Politicians are too easily attracted to the prospect of short-term results that suit the election cycle, rather than investing in policies which may take years to bear fruit. This can lead to the pushing through of policies as quickly as possible, often half-baked, and neglection of longer-term projects which are more usually complex.

For solutions, there's no shortage of ideas from policy think-tanks and political commentators around the world, ranging from strengthening the roles and functions of ombudsmen and

[111] Health and Disability System Review. Health and Disability System Review – Final Report – Pūrongo Whakamutunga. Wellington: HDSR, 2020.

[112] *He Ara Oranga*: Report of the Government Inquiry into Mental Health and Addiction, 2018

[113] Hudson B, Hunter D, Peckham S. Policy failure and the policy-implementation gap: can policy support programs help?, *Policy Design and Practice*, 2:1, 1-14.2019.

[114] National Audit Office. *Over-Optimism in Government Projects*. London, National Audit Office. 2013.

parliamentary committees, to setting up policy "delivery units" to track the implementation of policy, and establishing independent policy costings units.[115]

Discussion on the wide-ranging issues concerning the policy-implementation gap is beyond the scope of this publication. However, two approaches that relate to recent developments in Aotearoa New Zealand could potentially open the way for major improvements.

## Potential value of 'locality networks'

Health is a complex system: a policy intervention that is successful in one location does not necessarily deliver the same results elsewhere. This nuance is further complicated by policy-makers operating at higher levels without connection to what actually happens on, or close to, the frontline.

Policy design and implementation requires continuous collaboration with a range of stakeholders at multiple political, policy-making, managerial and administrative levels as well as the engagement of local "downstream" implementation actors such as patients, whānau, frontline staff, hapū and iwi, and a range of local service agencies. All of which emphasise the need for policy-makers to confront what has been described as "messy engagement of multiple players with diverse sources of knowledge".[116]

The planned health "locality networks" under the restructured health system present an opportunity for this engagement. These networks are intended to enable local communities to have a more direct voice to determine the shape and delivery of their health services are delivered. How they will operate is currently being piloted in nine communities, with a plan for between 60 and 80 localities by July 2024.[117]

The need for a bottom-up-top-down flow of information in both directions is emphasised in Max Rashbrooke's research report *Bridges Both Ways* about transforming the openness of Aotearoa New Zealand Government and improving democracy. Rashbrooke puts forward ideas for not only improving public participation about making government more accountable to communities.[118]

## Policy costing unit

Secondly, the establishment of an independent policy costings unit would enable public scrutiny of the feasibility of proposed political party policies and any social and economic impacts stemming from them. It would also incentivise political parties to improve their policy-making processes and develop better quality evidence-based polices.

In Australia, the Department of the Prime Minister and Cabinet has issued guidelines for policy proposals that are considered likely to exhibit "significant implementation risks or challenges." In such cases a full implementation plan has to be developed during the drafting process, covering

[115] Gold J. *International Delivery Centres of government and the drive for better policy implementation*, Mowat Centre, Canada, September 2014.

[116] Davies H, Nutley S, Walter I. Why 'Knowledge Transfer' Is Misconceived for Applied Social Research, *Journal of Health Services Research & Policy* 18 (3): 188–190, 2008.

[117] Little A (Hon). Locality network announcement, media release, Minister of Health, 21 April 2022.

[118] Rashbrooke M. *Bridges Both Ways: Transforming the openness of New Zealand government*, Institute for Governance and Policy Studies, Victoria University of Wellington, June 2017.

seven domains: planning, governance, stakeholder engagement, risks, monitoring, review and evaluation, resource management and management strategy.[119]

In Aotearoa New Zealand, plans to establish an independent policy costing unit, in the form of a Parliamentary Budget office, were included as part of the Labour-Greens confidence and supply agreement after the 2017 election. Plans for its establishment were opposed in 2019 by then-leader of the National Party, Simon Bridges, leading to the plans going on hold, given a requirement for unanimity to appoint a new Officer of Parliament (the desired model).

But in April this year, National's finance spokeswoman Nicola Willis wrote to Finance Minister Grant Robertson asking him to re-open discussions for an independent entity that would cost policies. Robertson is reported to remain interested in the idea "as resources and other priorities allow", but no timetable had been set down for that work.

Aotearoa New Zealand's history of political policy failures and broken promises demonstrate the need for stronger commitment from Government to work with opposition parties to set up an independent policy costings unit without delay. Willis is reported to be hopeful the unit could be established before the 2023 election.

## Better quality Parliament

Finally, adopting policies to improve health and wellbeing require long-term vision and commitment, and recognition that often it is an iterative process, in part due to the constantly changing nature of health and health care. However, while Parliament plays a fundamental role in holding the Government to account over its implementation of policy, the adversarial nature of Parliament and the temptation for MPs to engage in political theatre rather than in-depth scrutiny leads to government defensiveness and often achieves little in terms of solving the underlying issues.[120]

Good accountability creates an environment where lessons can be learned and policies can be improved. It requires intelligent debate to make room for cross-party agreements to enable good evidence-based policies, including agreement on sustainable health and social investment, over the longer term.

This requires a fundamental attitudinal change by MPs, moving from the prevailing political point-scoring game to an approach of engagement, learning and constructive policy-making.

[119] Australian Government. *Successful Implementation of Policy Initiatives*, Department of the Prime Minister and Cabinet October 2014.

[120] Guerin B, McCrae J, Shepheard M. *Accountability in Modern Government: Recommendations for Change*, Institute for Government, London 2018,

# Appendix: Vote Health Budget growth 2017/18 to 2022/23

**Budget 2017/18**

| | | |
|---|---|---|
| Vote Health | Operational | $16,176m (actual) |
| | Capital | $349m |
| | TOTAL | $16,525m |

---

**Budget 2022/23**

| | | |
|---|---|---|
| **Vote Health** | Operational | $22,358m |
| | Capital | $1,651m |
| | TOTAL | $24,009m |

| | | |
|---|---|---|
| **Vote Health** | Operational | $22,358m |
| | Minus Covid ($973m) | $21,385m |
| | Minus cost pressures of $1,307m (incl historical deficit cover, demographic change and inflation) | $20,078 |
| | Total in 2018$ | $17,551m |

---

**Real growth**

| | **17/18** | **2022/23** | **Growth** |
|---|---|---|---|
| Operational | 16,176 (actual) | 21,385[121] (budgeted) | 32.2% |
| | 18/19 | To June 2022 | |
| Wages from June 18 (66%) | 10,676m | 14,114m | |
| Other costs from June 18 (34%) | 5,500m | 7,271m | |
| Real (2018) wages | 10,676m | 12,241m | |
| Real other (2018) | 5,500m | 6,356m | |
| Total ($2018) | | 18,597m | |
| | | -1,307m cost pressures 2022/23[122] | |
| | | **17,290m (2018$)** | |

Demographic change June 2018 to June 2022 = 9.6%
Funding growth required (16,176m x 9.6%) **17,729m (2018$)**

**Difference June 2018 to June 2023 = -2.5%**

[121] Excludes Covid-related funding
[122] inflation, wage growth and demographic adjustments, plus historical cost pressures, identified for 2022/23

**Notes:**
Public health sector total wage and salaries growth June 2018 to June 2022 = 15.3%
Inflation June 2018 to June 2022 = 14.4%
Demographic change June 2018 to June 2022 = 9.6%

**Demographic adjustment (includes ageing effect) updated by MoH 1 April 2021**

| 18/19 | 19/20 | 20/21 | 21/22 | Total cumulative change |
|---|---|---|---|---|
| 2.34% | 2.69% | 2.37% | 1.88% | |
| 102.34 | 105.09 | 107.58 | 109.6 | 9.6% |

**Potential over-estimates and under-estimates**
The above demographic adjustments may be overstated for 20/21 and 21/22 as the latest population estimates indicated a sharp drop in the overall population growth in those years. On the other hand the population aged 65+ in those years increased by an estimated 3.2% and 2.9% respectively.

While CPI inflation estimates have been used, it is well recognised the health inflation – for which reliable data is not available in NZ – tends to be higher.

Estimated cost-pressures in 2022/23 are likely to be higher than stated as inflation is increasing at a rate higher than forecast at the time of the budget. The yet-to-be resolved nurses' pay settlement will also add substantially to cost pressures.