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 the health needs of our whānau and health workforce capacity.

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

1. Reducing the need for hospital care and emphasising equitable health outcomes
2. Tracing the origins of key medical workforce issues
3. Offering 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) for 2022-2024. Regardless of who governs the country now and in the future, these priorities embody sound principles for an effective and efficient health system.

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 NZ is in urgent need of a Health Workforce Strategy incorporating workforce plans from across the health professional groupings.

Download and read the full paper from the ASMS website

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

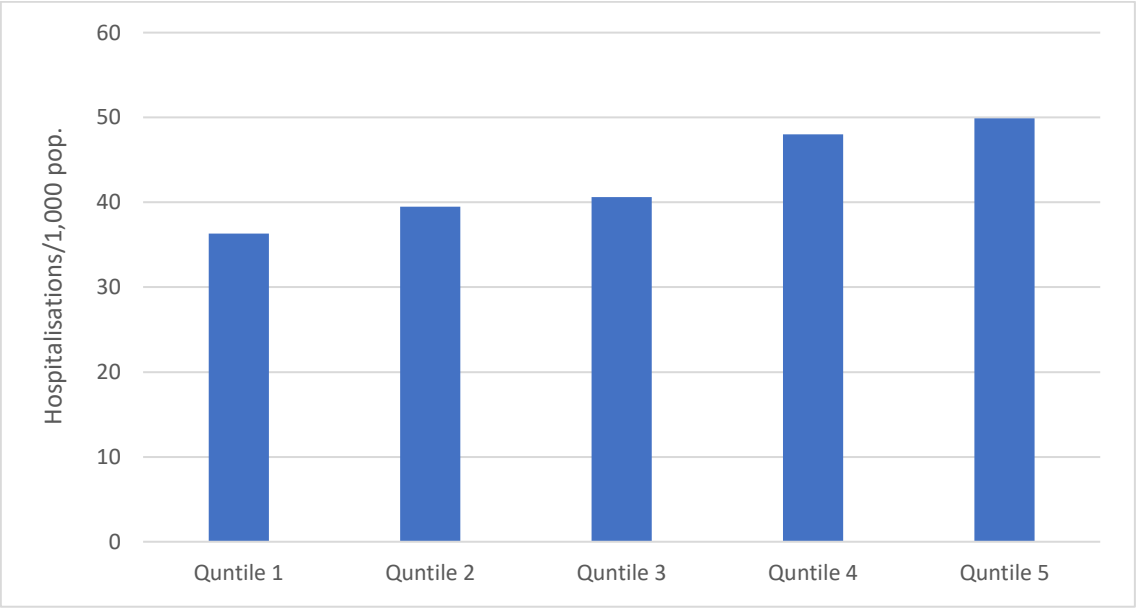
Key issues

Potentially avoidable hospitalisations

Hospitalisation rates are strongly influenced by social and economic environments. 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).

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.

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

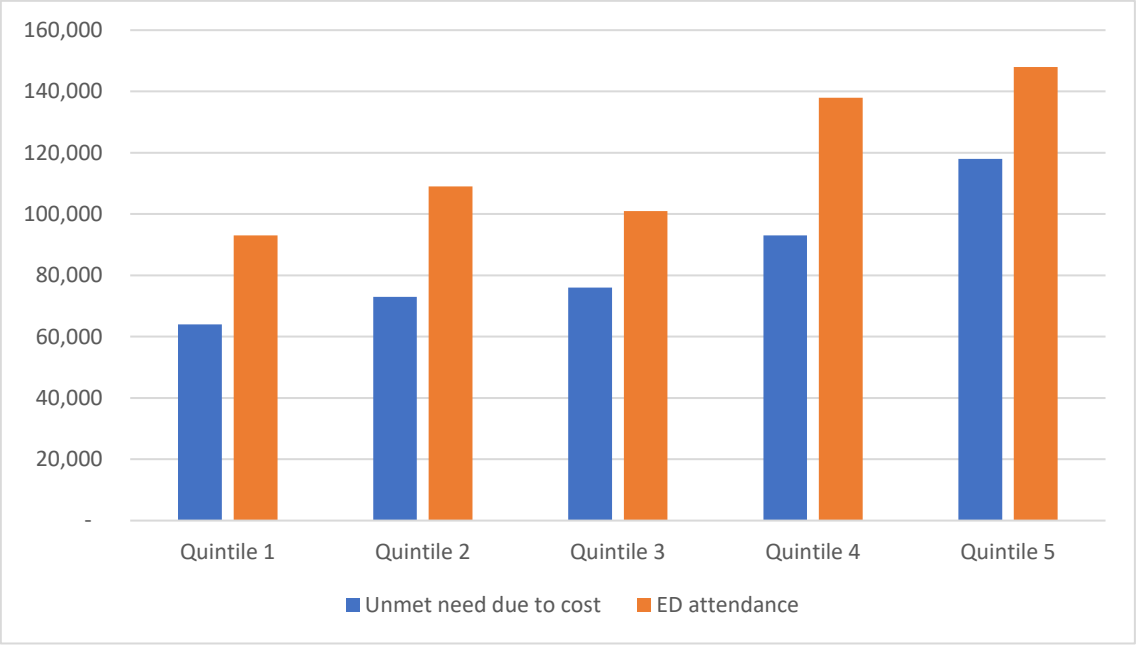


Source: National Minimum Dataset, 2022

Barriers to primary care

Primary health and dental care are out 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. Māori and Pasifika are significantly over-represented in these figures (Figure 2).

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



Source: NZ Health Survey 2020/21

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 NZ 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.

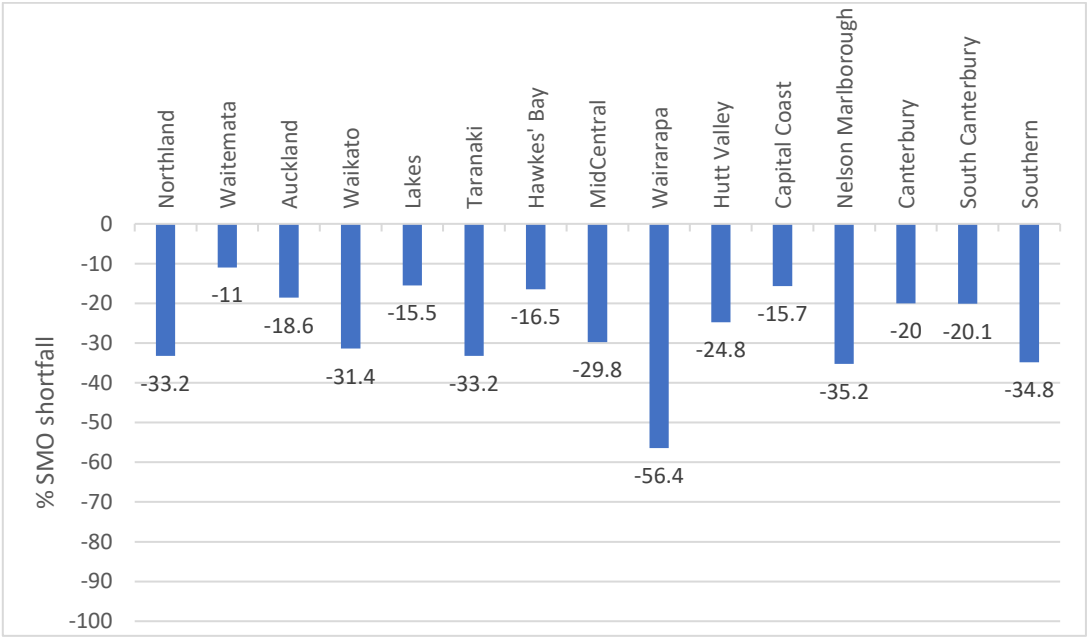
The medical workforce crisis

Key issues

Entrenched shortages of senior doctors and dentists

Te Whatu Ora's *Health Workforce Plan 2023/24* estimates a shortage of 1,700 doctors, including GPs, which is well short of ASMS estimates. ASMS surveys of Clinical Directors to establish their assessments of Senior Medical Officer (SMO) staffing levels in their departments, taking into account access, quality, safety, and unmet need, found an average 22% shortfall across all departments (Figure 3). The surveys, carried out across 15 districts in early 2022. Extrapolating those results to the total workforce, this would amount to a shortfall of more than 1,300 SMOs alone.

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

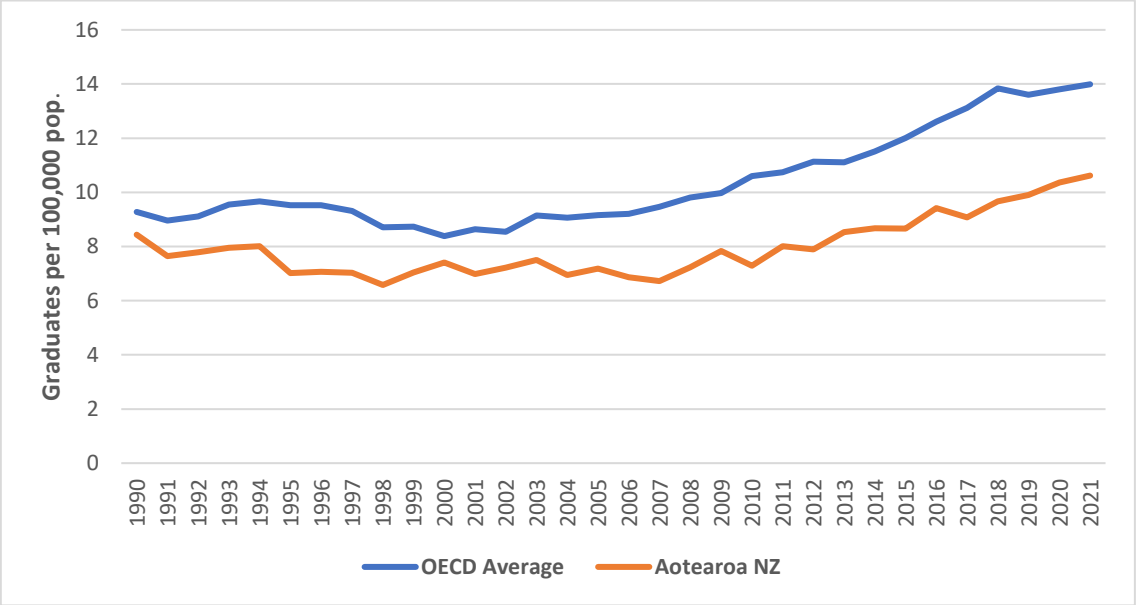


Source: ASMS 2022

Long-term shortage of medical graduates

The Aotearoa NZ medical workforce pipeline is affected by inadequate supply of medical graduates (figure 4).

Figure 4: Medical graduates per 100,000 population – NZ and OECD average, 1990-2021



Source OECD Health Data 2023

An ageing workforce

Fifteen per cent of the workforce is aged over 65 years in 16 of the Medical Council's 36 vocational scopes, including psychiatry, dermatology and general surgery.

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. In that same year 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

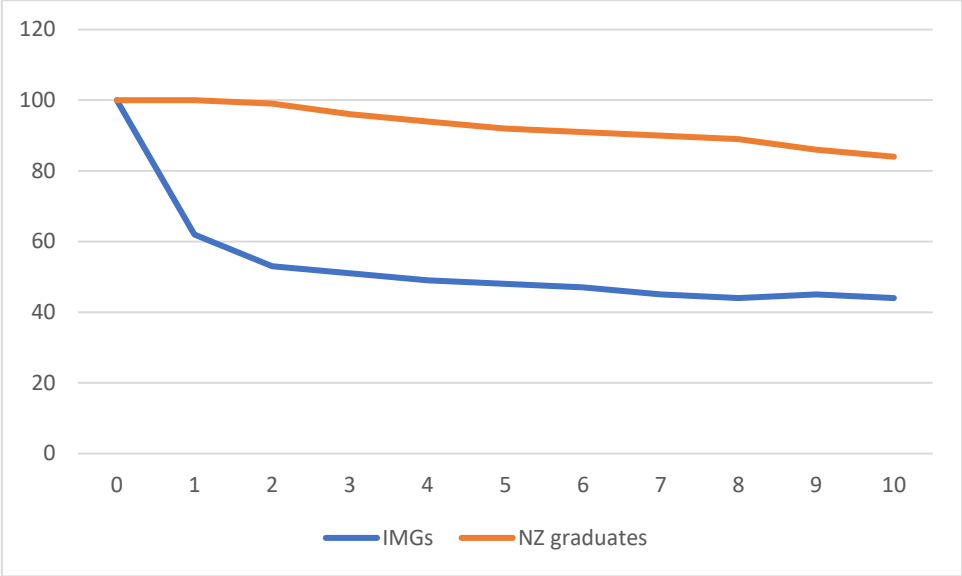
Anaesthesia	Oral & Maxillofacial Surgery
Cardiothoracic Surgery	Orthopaedic Surgery
Clinical Genetics	Otolaryngology Head & Neck Surgery
Dermatology	Paediatric Surgery
Diagnostic & Interventional Radiology	Pain Medicine
Family Planning & Reproductive Health	Palliative Medicine
General Practice	Pathology
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

Heavy 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.

Figure 5: Retention of IMGs and NZ graduates after general scope registration, based on average retention rates since 2010



Source MCNZ 2022

Sleepwalking into the future: No data, no detailed workforce plan

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.

Failure to implement policies

Reports dating back to at least 2000 show many health workforce issues have been long recognised, with policies intended to address them. Scant progress has been made in 25 years.

Recommendations

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.

1. Reform primary and oral health services

- **Eliminate user charges for primary health care and dental care**

  The upfront costs would be offset by savings in addressing unmet need. The limited information on the total cost of unmet need for primary care and dental care indicates it would be on a scale billions of dollars a year, most of it outside the health system. Implementation would be incremental as workforce shortages are addressed.

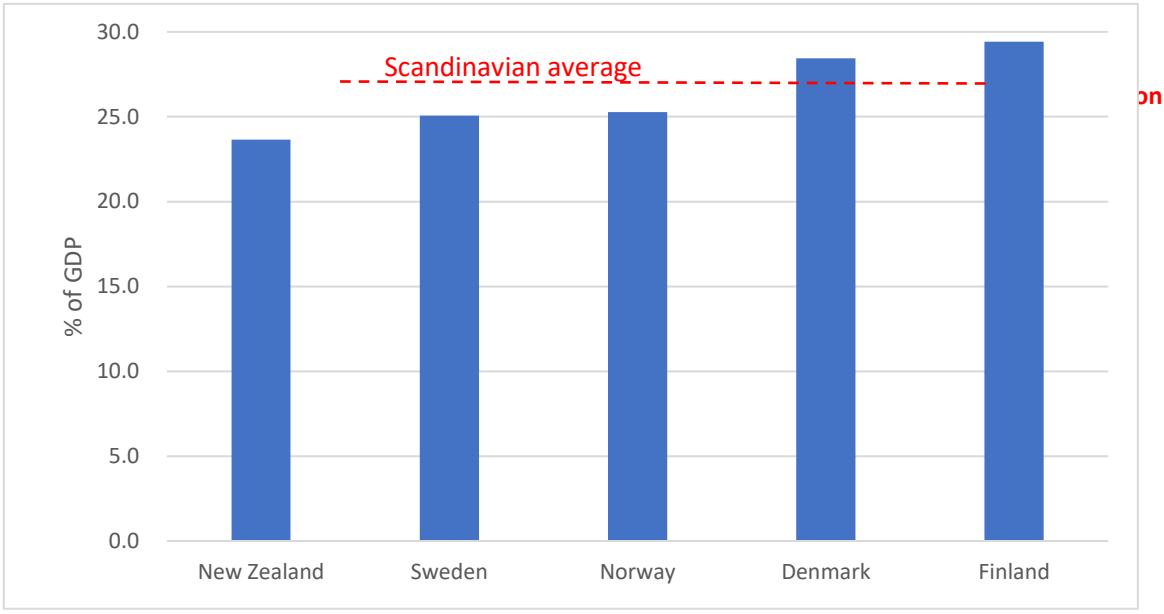
- **Reform primary health and dental care services to support fair population and geographic distribution**

  The private model has failed to provide accessible and equitable health care, both in terms of cost and location. To fill the service gaps, GPs should be employed as public specialists.

2. Reduce potentially avoidable hospitalisation rates through whole-of-government action

- Establish a Senior Minister and a dedicated Ministry for Public Wellbeing portfolio.
- Take a Te Tiriti o Waitangi principles approach to embed Health-for-All Policies across Ministries and government agencies
- Match investment to meet the drivers of population health needs, including housing, education, incomes, benefit levels, and food systems.
  The level of social spending in Scandinavian countries, which usually rank highly on wellbeing indicators, is a benchmark for achieving the Government's vision of social equity and high levels of wellbeing. Figure 6 gives an indicator of the scale of investment needed.

Figure 6: Public social expenditure per GDP for Scandinavian countries and Aotearoa New Zealand, 2019



Source: OECD Social expenditure data, 2023

1 2 3 5 6

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

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

4 5 6

4. Understand workforce capacity constraints

- 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

- 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

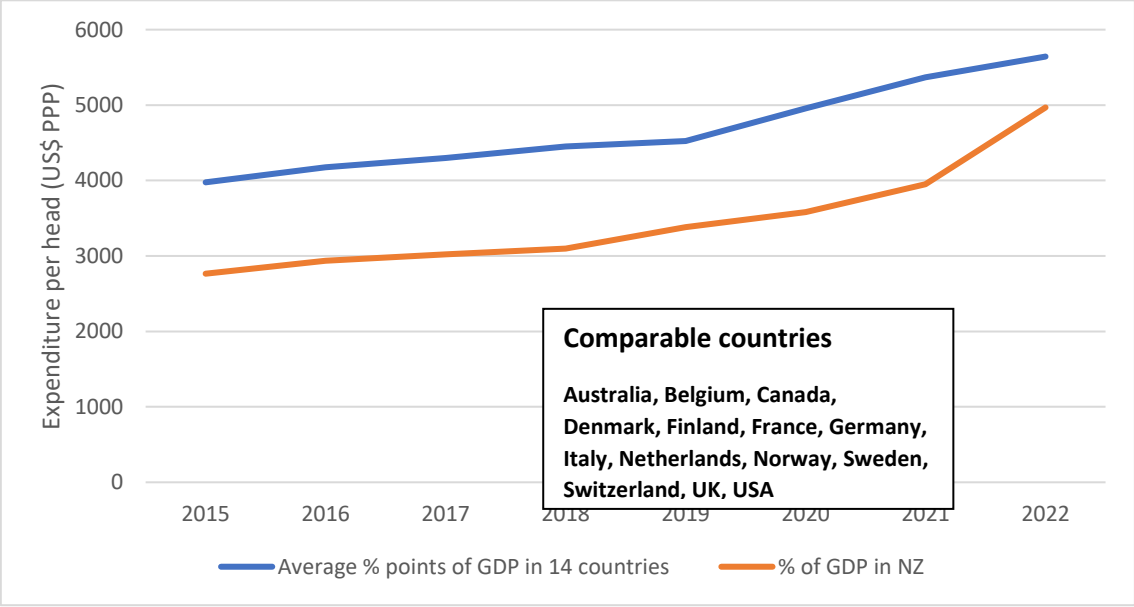
- Generate a gap analysis from the Workforce Census and unmet need data to form a basis for the plan
- That the plan and principles are founded on equity, inclusion, geographic distribution, specialty, and addressing workforce shortages

1 2 3 4 5 6

7. Investment decisions are data-driven

- Use the gap analysis from the Workforce Census and unmet need data to estimate current investment needs. Figure 7 gives is an indicator of the scale of investment needed to match comparable countries. (The recent trend will have been affected by one-off Covid-related funding.)
- Produce forecasts by speciality and match these to forecast service capacity needs

Figure 7: Total health expenditure per head (US$ PPP) – Aotearoa New Zealand and the average of 14 comparable countries, 2015-2022



Source OECD Health Data 2023

4 5 6

8. Grow capacity at undergraduate level

- Increase the numbers of doctors graduating from each New Zealand medical school to 300 by 2027

4 5 6

9. Strengthen postgraduate pathways

- 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

- Address immediate workforce shortages in the short-to-medium term through an international recruitment strategy
- 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

- Invest in the workforce and resourcing needs to build capacity in cultural safety, so that cultural loading is not an unintended outcome
- 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

- That power is shared, recognising the diversity of skills and expertise within the health workforce, and the knowledge and experience of communities
- 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

- Establish an independent Policy Costings Unit
- 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
- 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