DEPARTMENT OF THE PRIME MINISTER AND CABINET
TE TARI O TE PIRIMIA ME TE KOMITI MATUA

Proactive Release

The following documents have been proactively released by the Department of the Prime Minister and Cabinet (DPMC), on behalf of Hon Andrew Little, Minister of Health:

Health and Disability System Reform Briefings October 2021 to January 2022

The following documents have been included in this release:

Title of paper: Health Reforms: Realising the Digital Shift for the Health System

Title of paper: Development of the Interim Government Policy Statement for the Reformed Health and Disability System

Title of paper: Further advice on the Interim Government Policy Statement - Priorities for Inclusion

Title of paper: Health Reform: Choices to Expand the Public Offer

Title of paper: Health Reforms: Public Health Transformation

Title of paper: Health Reforms: Addressing Workforce Supply and Demand

Title of paper: Localities: Setting a Narrative, and Updating on Rollout and Prototypes

Title of paper: Further Advice on the Interim Government Policy Statement – High Level Approach to Priorities

Title of paper: Monitoring Arrangements for the New Health System

Title of paper: Restructure of Vote Health Appropriations to Support Health Reforms

Title of paper: Health Reform – Progress Update and Assurance Framework

Title of paper: Update on the Pae Ora Bill: Select Committee Progress and Further Policy Decisions

Title of paper: Pae Ora Bill: Key Policy Decisions for Recommendation in the Departmental Report

Title of paper: Allocation of Commissioning Budgets Across Future Health Entities

Title of paper: Health Reform: Transfer of Functions from Ministry of Health to New Entities

Some parts of this information release would not be appropriate to release and, if requested, would be withheld under the Official Information Act 1982 (the Act). Where this is the case, the relevant section of the Act that would apply has been identified. Where information has been withheld, no public interest has been identified that would outweigh the reasons for withholding it.

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Key to redaction codes:

- section 9(2)(a), to protect the privacy of individuals;
- section 9(2)(f)(iv), to maintain the confidentiality of advice tendered by or to Ministers and officials; and
- section 9(2)(g)(i), to maintain the effective conduct of public affairs through the free and frank expression of opinion.

~~IN CONFIDENCE~~

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BRIEFING

HEALTH REFORMS: ADDRESSING WORKFORCE SUPPLY AND DEMAND

To: Hon Andrew Little, Minister of Health; Hon Peeni Henare, Associate Minister of Health			
Date	5/11/2021	**Priority**	Medium
Deadline	19/11/2021	**Briefing Number**	DPMC-2021/22-750

Purpose

This briefing explores what is needed to ensure our workforce is sustainable, proactively managed, equity enabling, unified and fairer over the next 20 years. It examines both the fundamental shifts in workforce settings which will be required over time, and what needs to happen in the short-term (through to 2024) to set us on the right track, while also managing the short- and medium-term pressures which the Ministry, Health NZ and Māori Health Authority will face.

Recommendations

a. **Note** that solving challenges in the supply and demand of our health workforce will be difficult, and will require concerted effort from agencies over time – even following structural and regulatory changes which will significantly improve the performance of our workforce system.

b. **Note** that in future, health agencies will need to much more proactively gather and analyse data on workforce supply and demand to build an accurate picture of the current state of workforce sufficiency, and then model demographic shifts alongside changes in models of care to allow for early intervention, and maintenance of a sustainable workforce.

c. **Note** that over time, education and training programmes for the health workforce will need to become much more flexible, agile and innovative to grow the numbers, diversity and capabilities needed in our health workforce.

d. **Agree** to set expectations for interim boards through the interim Government Policy Statement as to your expectations on workforce planning, intervention and training for future entities. **Yes / No**

e. **Agree** that the Transition Unit brief interim boards on workforce supply and demand and the initial infrastructure needed to get it working well – and support interim agencies as required to grow required functions. **Yes / No**

f. **Note** that that the interim NZ Health Plan will signal the shift in workforce data collection and analysis needed through to 2024, including opportunities to make use of models of care and novel education and training models to strengthen workforce sustainability.

g. **Note** that in developing key artefacts for the future system, we will identify opportunities to highlight consideration of workforce pressures and factors, including how tools and frameworks can ensure workforce implications are well considered in commissioning decisions.

h. s9(2)(f)(iv) [redacted] **Yes / No**

i. **Note** that you may wish to discuss with the Minister of Education your shared expectations for health and education agencies as to your cross-agency working, and the shifts you expect to see in health workforce education and training settings.

j. **Note** that there will be opportunities through the interim NZ Health Plan, Budget 22 investments and the reform of the Health Practitioners Competence Assurance Act 2003 to make early headway on innovative models of care and education and training initiatives which can strengthen workforce sustainability and performance.

pp Stephen McKernan Director **Health Transition Unit**	Hon Andrew Little Minister of Health
5/11/2021	…../…../….

Hon Peeni Henare Associate Minister of Health
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HEALTH REFORMS: ADDRESSING WORKFORCE SUPPLY AND DEMAND

Context

1. You have already received advice from us on various aspects of health reform which will strengthen our health workforce, including on:

    a. overall future system structures, roles and responsibilities [CAB-21-MIN-0092; DPMC-2020/21-1128 refers]

    b. a planning framework – centred around the Government Policy Statement and NZ Health Plan – which will make it much easier to understand care needs and workforce pressures [DPMC-2021/22-292 refers]

    c. reform of the Health Practitioners Competence Assurance Act 2003 (the HPCAA), which will ensure government can better influence and drive changes to education and training, regulatory practice, and scopes of practice [DPMC-2020/21-1128; HR20211690 refers]

    d. strengthening employment relations settings and roles to ensure a more strategic approach [DPMC-2021/22-196 refers].

2. This advice focuses both on how you can manage issues of supply and demand to achieve the system shifts which are the focus of health reforms, and your vision for the health workforce: that it is proactively managed, equity enabling, more unified, fairer, and with health being a career of choice [DPMC-2020/21-1128 refers]. This includes ensuring that approaches to supply and demand centre, and are grounded in, te Tiriti o Waitangi.

3. This advice complements and contextualises advice you have recently received, and expect to receive, from the Ministries of Health and Education on a work programme to strengthen education settings and programmes for the health workforce.

The challenge

4. In previous advice, we have highlighted at some length the challenges to achieving your vision for the health workforce today [DPMC2020/21-1128 refers]. Though there are layers to the challenges facing our health workforce, fundamentally, we currently do not:

    a. recruit and retain the right number of people, with the right skills and capability, across the health system

    b. maintain a representative workforce where Māori, Pacific peoples, disabled people and other underserved communities are visible and widely represented

    c. make best use of the workforce we have.

5. These challenges apply across a range of workforces, from clinical workforces through to enabling roles in digital services, commissioning, and management, each with their own unique contexts and barriers.

6. Successive reforms have failed to make enough headway in addressing these problems. In large part, this is because addressing these problems sustainably is hard, and requires alignment between system settings such as regulation, funding and management – as well as continued and concerted efforts to drive change across agencies (including those beyond health with a stake in the health workforce). These fundamental challenges flow on to, and are driven by, issues in how we train, retain and support our workforce.

7. To some extent, the risks facing the workforce can be mitigated within today's settings, such as through recruitment campaigns, retention initiatives, scholarships or piloting new models of care. We explore these mitigations below. These are important elements of how we achieve the system shifts and your vision for the health workforce.

8. However, to meaningfully address long-term issues of supply and demand, we must transform some of the premises of our workforce system to fundamentally change people's experiences – both of care, and of participating in the health workforce. Unless these drivers are addressed, the pattern of issues we have today will likely recur over time.

9. We consider that three practical but transformative changes in how the health workforce is planned, trained, and managed will make very significant progress towards solving persistent problems and achieving your vision for the health workforce:

    a. **Strategic workforce planning:** Our workforce must be planned in real time, looking as much to decades in the future as to today. This includes modelling future demand, identifying potential shortfalls, and intervening early to ensure sustainability.

    b. **Flexible, innovative education and training:** Education and training pathways need to become flexible and agile, removing barriers to entry and focusing on what people need to know and do to practice safely and well. In practice, this looks like a shift towards on-the-job training, digital-driven learning, recognition of prior learning, more accessible training programmes (both in terms of duration and cost), better staircasing, and programmes grounded in te ao Māori and Pacific worldviews becoming standard practice over time.

    c. **A better experience of working in health:** Working in health will need to be more flexible and empowering, with more people working at top of scope and greater opportunities to move between careers. It also means stronger interprofessional culture and leadership, fairer pay and conditions, and embedding norms of flexible working to the extent possible.

10. Achieving these shifts will be challenging and will take time, but it is vital that progress starts soon and is sustained. Future health agencies will need to use a whole range of levers (both relational and structural), to improve commissioning, service design, and employment relations to slowly shift practice over time. The future health system will need to balance early progress to tackle immediate supply pressures with making headway towards long-term shifts, with continuous movements towards the desired future state needed.

11. All of these changes will need to be effected in a way which centres equity – emphasising our Māori, Pacific and disabled workforces – and which is grounded in te Tiriti o Waitangi. This includes both delivering on the Māori Health Authority's partnership role in workforce policy, strategy, planning and commissioning, and ensuring that Māori are involved and given space to lead in how we plan, train and support our workforce.

12. The remainder of this paper focuses on what needs to happen over the next three years to start achieving the first two transformations: to workforce planning, and to education and training. The third fundamental shift, focused on the experience of working in health, will be addressed in more detail in a future paper to ensure a fulsome exploration of the complex challenges raised by this shift.

Strategic workforce planning

13. As we have advised you previously, one of the major causes of our workforce supply challenges is the disconnect between inputs which affect supply (e.g. education and training programmes, funding, interest in health careers), system demands (e.g. population needs and changing models of care), and the levers available to the Ministry of Health to respond. To ensure that we can continuously match supply pressures to demand pressures, our future system will need to operate differently.

14. Over the past 20 years, system structures have been a significant barrier to strengthened workforce planning – with the fragmentation across DHBs, shared service agencies and the Ministry of Health driving a similar fragmentation in understanding and managing supply and demand. While these barriers will not exist in the same way in the future system, the aspiration of completely mastering supply and demand pressures is yet some way off.

15. Moving towards that aspiration will require investment over time. We consider that relatively rapid headway can be made by future health agencies with the right direction and focus on workforce planning and management.

16. By 2024, agencies will need to have made significant progress in two key areas:

    a. building a much more sophisticated and accurate picture of supply and demand issues for the workforce

    b. developing a better suite of levers than agencies have today to respond when issues are identified.

17. We envisage that this will be achieved by utilising a range of levers, including:

    a. the development of a workforce strategy (led by the Ministry of Health)

    b. the Government Policy Statement (GPS), which will set system direction for workforce planning

    c. the NZ Health Plan, which will set new expectations for how we plan and deliver care – and identify the workforce implications of those decisions.

18. In the future system, Health NZ and the Māori Health Authority will be uniquely placed to maintain sight across supply opportunities and pressures, the implications of

shifting models of care, and the needs of both primary and community-based and hospital and specialist services nationwide.

Building a more sophisticated and accurate picture of supply and demand

19. In future, Health NZ and the Māori Health Authority will need a clear picture of the care New Zealanders expect to access, aligned to new models of care, and from this scope the workforce required to deliver on those expectations.

20. At present, we have relatively good data in some areas – such as about workforce numbers in our hospital and specialist system, and in professions regulated under the HPCAA – and relatively poor data in other areas, such as for unregulated or self-regulated workforces. Our understanding of workforces not on the frontline, such as commissioners, and of future demand, is also lacking. Over the next three years, agencies will need to change this by:

    a. agreeing what data they need to collect to understand the workforce fully – considering not only roles, but also the skills and capabilities of the workforce – and communicating this clearly across providers and government

    b. using accountabilities (the GPS and NZ Health Plan), management (e.g. directives to hospital networks), regulatory (through the HPCAA reforms) and commissioning levers (e.g. data requirements in contracts) to ensure that they collect this data to agreed national standards, ensuring accuracy

    c. drawing this data together into a comprehensive picture of both supply and demand pressures, including using tools such as health needs assessments to reflect nationwide pressures

    d. making use of predictive modelling to anticipate future pressures and areas of need, including the implications of changes to demand pressures – with a focus on ensuring that when new models of care or policies are adopted, the workforce implications are accurately modelled and analysed.

21. We anticipate that Health NZ will lead the substantive work in this area, but with data needs and supply-demand models jointly developed with the Māori Health Authority to ensure capture of data which is important to Māori (e.g. iwi affiliation) and appropriate modelling. The Ministry of Health will continue to support the regulatory and system settings needed to ensure this collection occurs, monitor performance, and coordinate across government to align across the other sectors who employ health workforces. Monitoring performance could include metrics regarding productivity, how well our workforce is being used across the system, and the growth of workforce to match demand.

22. The Ministry has already begun work on improving data collection, including work on a data collection programme for the employed and funded workforce. Additionally, the Health Practitioner Index (HPI, a national index of health practitioners) is in the process of being updated to support the storage of non-regulated workforce data. These steps will help Health NZ and the Authority begin on the right foot.

23. The future health entities will need to consider how to use contractual mechanisms to ensure disclosure of the workforce data and intelligence we need to understand the current state and likely future trends (without excessively burdening providers), alongside leveraging relationships with other agencies, such as the Tertiary Education Commission, to collect what they need.

24. Over time, it is desirable that agencies' understanding of workforce data and modelling be supported by appropriate digital infrastructure, and in some cases this will be vital to allow for collection and analysis. Health Workforce Australia, for example, has developed a publicly-accessible digital tool that models the workforce impacts of different models of care, improving accountability and allowing people to test different ways of configuring the workforce. While in general agencies' immediate focus should not be digital infrastructure – it is more important to get the fundamental data and analysis right first – working towards this kind of solution over time would grow transparency and ensure better, live tracking of supply and demand pressures. To ensure this change happens, we recommend that:

    a. you set clear expectations for boards through the interim Government Policy Statement as to how a much sharper picture of the health workforce should come together, which may include ensuring visibility in boards' work programmes

    b. the interim NZ Health Plan signal the shift in workforce data collection and analysis needed, and provide direction on how it will be achieved by agencies over the two years to 2024

    c. the Transition Unit brief the interim Health NZ and Māori Health Authority boards on workforce planning, and the initial infrastructure needed to get it working well, and support the boards as required to grow these functions within interim entities

    d. the need for a strong workforce data and planning function, particularly in Health NZ, be considered by the Transition Unit and interim entities when developing recommended operating models and workforce structures for the interim boards.

Proactively responding to shortfalls

25. Understanding workforce gaps, and the implications of decisions about models of care, is a vital first step to a better managed workforce. However, identifying supply-demand gaps will not be enough if Health NZ and the Māori Health Authority cannot address them. Today, even where agencies are able to identify gaps in workforce supply and demand early, they often lack the ability to proactively respond.

26. Agencies will need a range of levers to grow or shift supply, manage attrition, and manage demand where shortfalls are identified. This will need to include both levers which Health NZ and the Māori Health Authority can use regularly, and without further approval (to manage year-to-year shifts in supply and demand patterns), as well as more substantial levers exercised in partnership with the Ministry of Health to address more significant or fundamental problems.

27. Over the next three years, developing these levers is a priority. Agencies will need these to tackle the problems of today, and to build a culture of early identification and intervention. While organisational maturity will build as Health NZ and the Māori Health Authority embed, and the Ministry of Health adapts to its new system role, we expect that by the first full NZ Health Plan, levers in the following areas will be in use to some extent:

    a. *Changing models of care.* Models of care have a significant impact on demand, and affect what roles, skills and capabilities we need to meet New

Zealanders' care needs. Health NZ and the Māori Health Authority can shift dominant models of care strategically to both improve patient outcomes and achieve workforce sustainability – making best use of the workforce we already have (such as by ensuring people practice at top of scope). This is one of the best short- and medium-term levers agencies will have to tackle endemic shortages.

b. *Modifying education and training programmes.* The nature of education and training available, including programme length, cost, difficulty, content and cultural lens, can be strong levers to improve sustainability over time. Education models are, however, traditionally hard to shift (requiring consensus with education agencies, responsible authorities, professional bodies, unions and Workforce Development Councils). We discuss this lever in more detail below.

c. *External communications*. These might range from recruitment campaigns to initiatives targeted at students in secondary school and second chance learners to encourage them into health careers, or to partnerships with training institutions to encourage prospective trainees to train in professions or specialisations which are undersubscribed or at risk.

d. *Shifting funding and incentives.* Funding is already used to encourage people into health careers, such as through scholarships and measures like the Voluntary Bonding Scheme (offering student loan relief for service in under-pressure areas). A range of similar mechanisms could be used to bolster at-risk professions and areas, ranging from incentivising retraining or return to practice, or funding end-to-end pathway support for Māori and Pacific students.

e. *Making use of employment relations.* Changes to rates of pay or the terms and conditions of work are potentially powerful influencers of both training volumes and attrition (though often at high cost to government, and constrained by what can be achieved through good faith negotiation).

f. *Management.* Retraining or redeploying staff – particularly within similar settings in the same area – can be effective at short-term demand management, within employment relations and appropriate labour constraints. Over time, shifting the profile of the workforce alongside changes to models of care can improve sustainability.

g. *Commissioning.* Commissioning is a significant workforce lever, and the way that we plan care, commission and manage all affects workforce profile and supply. This includes through the kinds of roles we fund or incentivise through funding structures, the sorts of care that we buy and who we expect to provide it, and through the impact of contracting on the pay and conditions of the funded workforce.

h. *Making use of immigration settings and pathways.* Strong connections to immigration agencies and settings, including pathways for retraining and upskilling (e.g. in te ao Māori and culturally responsive care), has traditionally been, and will continue to be, a key lever to influence workforce supply.

28. It is vital that these levers be in common use, and be flexible to work across professions in a variety of contexts. For example, in some instances, low supply might

be driven primarily by high attrition from employment or training pathways (which might require intervention using employment or education levers), while in other cases voluntary bonding or student loan relief may be a useful incentive to participation.

How we ensure a shift in practice as the future system embeds

29. By 2024, Health NZ and the Māori Health Authority should be working comfortably in partnership and using these levers to shape future supply, and manage the pressures of today. As noted above, a degree of flexibility to use these levers day-to-day will be key to building a culture of proactive management.

30. The Ministry of Health will have access to further levers in cases of more serious deficits or structural problems – including policy levers to shift system settings, regulatory levers (such as through the reform of the HPCAA), and influence over other agencies' settings (e.g. in immigration). The Ministry will also have a vital role in connecting Health NZ and the Māori Health Authority's needs with wider supply and demand pressures from other government sectors (e.g. Corrections) which also make use of the health workforce.

31. The Māori Health Authority will similarly be better placed to take certain actions, such as investing in Māori workforce development within Māori providers, and shaping commissioned kaupapa Māori services. It will take a lead in ensuring that opportunities for Māori to lead interventions – such as using iwi-led education and training pathways – are part of the solution. Agencies will need to work in partnership to ensure they make use of these levers in concert, though we anticipate that Health NZ will act as the lead agency in managing supply and demand for the new entities.

32. All of these levers will need to be used with an acute focus on equity and representation across our workforce. In the near future, the emphasis of recruitment and training investments should be on Māori and Pacific people, particularly in clinical and leadership roles where they are most underrepresented. This will need to be accompanied by shifts in leadership in culture, which we discuss further below.

33. The above levers have been built into the new health entities' ambits, to be used in partnership with one another. The key to making this happen will be to ensure that agencies are comfortable with, and focused on, using them regularly. To make this happen, we recommend that:

    a. the interim NZ Health Plan highlights opportunities to make use of models of care to strengthen workforce sustainability alongside improving patient outcomes, particularly by giving practitioners more opportunities to work at top of scope

    b. commissioning frameworks and similar key documents highlight consideration of workforce pressures and factors, and that the future roadmap for these frameworks include the development of tools to assess the workforce implications of commissioning decisions

    c. at least a proportion of funding reallocated to Health NZ and the Māori Health Authority from DHBs for workforce development be applied to a flexible fund, designed to adapt and respond to emergent need over time (noting that strong workforce commissioning practice will be needed to ensure this funding remains flexible and does not become permanently committed over time).

34. Workforce initiatives progressed through Budget 22, including end-to-end pipeline support for Māori and Pacific students, recruitment and retention campaigns, and incentive schemes, will also help to embed the approaches and practices we want to see in the future, by starting Health NZ and the Māori Health Authority out with investments and initiatives in the above areas. Similarly, the employment relations approach and structure previously agreed with you [DPMC-2021/22-196 refers], including the development of a workforce strategy and employment relations strategic plans, will facilitate effective use of employment relations levers.

35. Below, we set out examples of what these initiatives might look like in practice and the impact they could have – noting the examples provided may not be those implemented.

s9(2)(f)(iv)

Role of the interim NZ Health Plan

36. The interim NZ Health Plan, which will be developed prior to Day 1 of the future health system, will present further opportunities to articulate new models of care or approaches that make better use of our current workforce's scopes of practice, and allow for new development of skills and capabilities.

37. The interim NZ Health Plan will provide an outline of key workforce initiatives, and next steps to build on current sector strengths towards delivering new models of care between Day 1 and 2024. This will include an initial focus on developing a health workforce that is better placed to address inequity, wellbeing and prevention of illness,

and the provision of whānau-centred care. It will also signal the commencement of areas of focus for the sector, including where current best practice has the ability to be scaled for wider implementation.

38. Growing and developing our Māori, Pacific and disabled workforces will be central to this shift. New models of care will translate into direction to the make-up of our workforce, which is likely to include a greater emphasis on kaupapa Māori models, and enabling people to work at the top of their scope and within highly functioning teams. Digital tools, clinical networks and strong leadership will support the workforce to do so, drawing on examples of good practice. Literacy in digital skills and cultural competency will be needed to achieve this change.

Agile, flexible and innovative education and training

39. As noted above, there are many levers which can strengthen health workforce supply – but none are as influential as education and training. While factors such as retention are important to ensuring we have the right number of people, education and training affects who works in health, how many people work in health, what those people know and can do, and their roles, scopes, cultures and identities as professionals. Strengthening education and training is therefore essential to achieving your vision for the health workforce, given its strong influence across all of the fundamental problems identified earlier in this paper.

40. Given this significant role and influence the opportunities for improvement are many. We consider that the essential areas for movement are:

    a. Shifting towards a greater emphasis on what people know and can do, rather than just their job titles – which looks like more staircasing of skills and qualifications. This includes the potential to recognise overlapping competencies across professions, making it easier to retrain or move into different professions.

    b. Growing Māori and Pacific workforces, including through tailored programmes grounded in Māori and Pacific worldviews and practice, lifting all teaching and practice to be culturally responsive, and providing early opportunities to encourage Māori and Pacific peoples into health professions, with support across the training pipeline.

    c. Shifting to training models that better recognise the realities of people's lives, including a move to more flexible on-the-job training (away from more rigid approaches), better recognition of prior learning, including experience gained from voluntary and whānau care roles, and opening pathways by having more diverse entry routes.

    d. Improving in-career development, so that people have a range of opportunities to build their skill sets and have these reflected in qualifications that evidence their abilities, and to ensure they stay up to date with best practice.

    e. Changing what people learn, to ensure that alongside professional capabilities (which our education and training programmes do a good job of growing) we develop people who are empathetic, culturally safe and conscious of the lived experiences of Māori, Pacific peoples, disabled people, LGBTQI+ people, and underserved communities, as well as skilled in interdisciplinary working.

f. As indicated above, ensuring that education and training programmes are more adaptive and responsive to emergent supply and demand pressures – including by lowering barriers to entry to professions through qualification and programme design, and nudging students towards pathways which are in greater need.

g. Digitally capable and literate leadership and workforce will be vital to realise the improvements offered by digital and data. Variable capability and a lack of coordinated, formal pathways will need to be addressed to take advantage of the opportunities of reform.

h. Generally growing the capacity and volume of training programmes.

41. In making progress in these areas, it will be important for agencies to consider workforces beyond those on the frontline – including enabling workforces such as commissioners and digital health experts. In many of these areas career pathways do not yet exist or lack visibility, though the new system operating model will open some pathways which were not prevalent before, such as improving progression in commissioning roles within Health NZ and the Māori Health Authority.

42. For other areas, there is not yet training readily available because demand is still growing: for example, a limited market for digital health training programmes in New Zealand makes it harder to train more digital health practitioners, as we would like. Investment will therefore be needed to both grow and refine pathways, as well as encouraging people to participate in them, if endemic challenges are to be addressed.

Driving a shift in education and training practice

43. In our previous advice on regulatory reform [DPMC-2020/21-1128; HR20211690 refers], we highlighted that one of the main rationales for regulatory reform is to improve the connection and sense of shared direction between health agencies and responsible authorities in shaping education and training programmes. Planned reforms to the HPCAA will help matters but even following regulatory reform, the number of stakeholders involved in strengthening education and training will require concerted effort to make swift progress.

44. Where Health NZ will tend to lead on workforce planning and management for health services, we anticipate the Ministry of Health and Māori Health Authority leading more on strengthening education and training. The Ministry of Health is already working with the Ministry of Education on a shared programme to strengthen education and training settings – and the Ministry will continue to hold many of the relationships and levers which enable it to shift these settings. The Māori Health Authority will hold close relationships with Māori providers and education providers, and will take a leadership role in shaping culturally diverse and safe training pathways. However, Health NZ will also play a vital role in providing operational expertise, and a deeper understanding of the professions, skills and capabilities which it needs to deliver on models of care.

45. It will therefore be vital that agencies are well-mandated and supported to use what levers they will have to influence education and training. To make headway by 2024, when regulatory settings will support agencies to have a stronger formal role, we recommend that:

a. you and the Minister of Education discuss and set clear expectations for both health and education agencies as to the manner of cross-agency collaboration

you expect, and the kinds of shifts you expect to see in education and training settings

b. the interim NZ Health Plan highlight opportunities to explore or pilot novel education and training models within services, in collaboration with training and education providers

c. through its commissioning approaches, frameworks and documents, Health NZ and the Māori Health Authority increase funding for primary and community-based care providers to take on postgraduate students or students on placement across professions, subject to any funding required through Budget 22 (already included in proposed packages)

d. opportunities be identified through the regulatory reform programme for the HPCAA to make early headway on key innovative education and training initiatives, in partnership with responsible authorities and professional bodies.

46. The vignette below illustrates the kind of change which we would expect to see more frequently in the future system, if these shifts in practice are working well.

s9(2)(f)(iv)

Opportunities for early progress and prototyping

47. Your proposed Budget 22 initiatives also offer opportunities to make early progress in key areas to embed a culture of innovation and education and training expertise within agencies from the outset. Between Budget 22 initiatives and the interim Health Plan, we expect to identify around five to ten areas for relatively rapid prototyping, design and development, working in concert with the sector.

48. We will provide you with further advice on the areas to be progressed following further development work on the interim NZ Health Plan, as part of our advice on how we will deliver Budget 22 initiatives.

49. Further examples of the type of initiatives we expect to progress include:

    a. strengthening the staircasing of kaiāwhina qualifications and pathways to retain workforces employed through the COVID-19 response (e.g. vaccinators)

    b. investing in rural generalist models to allow rural GPs to work at top of scope, and build areas of specialty which allow more procedures (e.g. in obstetrics and gynaecology and anaesthetics) to occur rurally

    c. growing pathways for allied health professionals to facilitate new models of care – such as by improving growth in accuracy technicians to allow pharmacists to work at top of scope, focusing on medicines review or prescribing instead of dispensing

    d. whole-of-pathway support for Māori and Pacific students to start and stay on health pathways

    e. exploring opportunities for iwi-led, localised training programmes that support recruitment and retention of rangatahi Māori in health careers within iwi rohe

    f. building better pathways for enabling professions, such as commissioners and digital health experts, where these don't currently exist

    g. developing a rural interdisciplinary training programme as discussed in recent advice from the Ministry of Health [HR20202093 refers].

50. As noted above in relation to workforce planning, all early interventions should focus on Māori and Pacific workforces, to make headway towards greater representation in key workforces. This will require a measure of co-design with Māori (including Iwi-Māori Partnership Boards, Māori training providers such as wānanga, and Māori providers) and Pacific people.

Risks and barriers

51. In opening this paper, we noted that many of the problems with our workforce's sustainability are complex and belie simple solutions. This means it is prudent to consider where risks and barriers to delivering on this model may impede us making progress through these reforms.

52. The system structures that have been a significant barrier to workforce planning over the past 20 years, including fragmentation across DHBs, will not endure in the future system. Even so, we consider that there are three key risks to delivering on the change outlined above:

a. Competing demands on the priorities of Health NZ and the Māori Health Authority, both during the transition period for interim entities and after Day 1, may mean that the needed infrastructure to work differently is not put in place, or is insufficient to achieve the needed change.

b. Agencies will be constrained by the resources and features of today's system in some respects – for example, shortages in senior staff make it more difficult to develop more junior staff. These constraints may impede agencies' efforts to strengthen our workforce system, particularly if not prioritised.

c. Even following structural and regulatory changes, strong and enduring relationships with wider government agencies (such as on education and immigration settings) and other actors (such as responsible authorities and tertiary providers) will be needed to make progress in most areas. This is hard to assure, and will rely on both capability and momentum to sustain change.

53. We expect directions to boards, firm direction in key artefacts (such as the GPS), ongoing monitoring by the Transition Unit and Ministry of Health and defining areas for early progress through Budget 22 and the interim NZ Health Plan will mitigate these risks. Concrete early deliverables through the interim NZ Health Plan and Budget 22 will create opportunities for government to 'bring something to the table' and maintain stakeholder engagement, which will be further mitigated by ensuring sufficient capacity and capability within the future Ministry of Health, Health NZ and Māori Health Authority to deliver on needed functions.

54. As the transition period progresses, we will continue to advise you if these risks change, and will consider whether further mitigations or steps are needed over time to ensure workforce reforms are successful.

Consultation

55. The Ministry of Health, Treasury and Public Service Commission have been consulted on this paper.

Next steps

56. Subject to your agreement, we will take steps to brief and involve the boards of interim Health NZ and the interim Māori Health Authority in key activities needed to make progress in each of the above areas. We will also continue to work with the Ministry of Health to ensure that links to other work programmes – including the transition of staff to Health NZ and the regulatory reform programme – are strong, and that initiatives remain well aligned.

57. We will provide you with further advice through the Budget 22 process, and as we develop the interim NZ Health Plan on how funding and resources can be applied to achieve the specific purposes and initiatives highlighted here.