



# **Towards a sustainable, diversified and fit for purpose health workforce**

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Executive Chairman

# Towards a sustainable, diversified and fit for purpose health workforce

- A challenged health system – the New Zealand health system in 2009/10; the *cassis belli* for reform of the health workforce
  - Friday 11 June 2010 0830-0900
- The way ahead - diversification of the New Zealand health workforce through intelligence, innovation and clinical leadership
  - Friday 11 June 2010 0950-1020



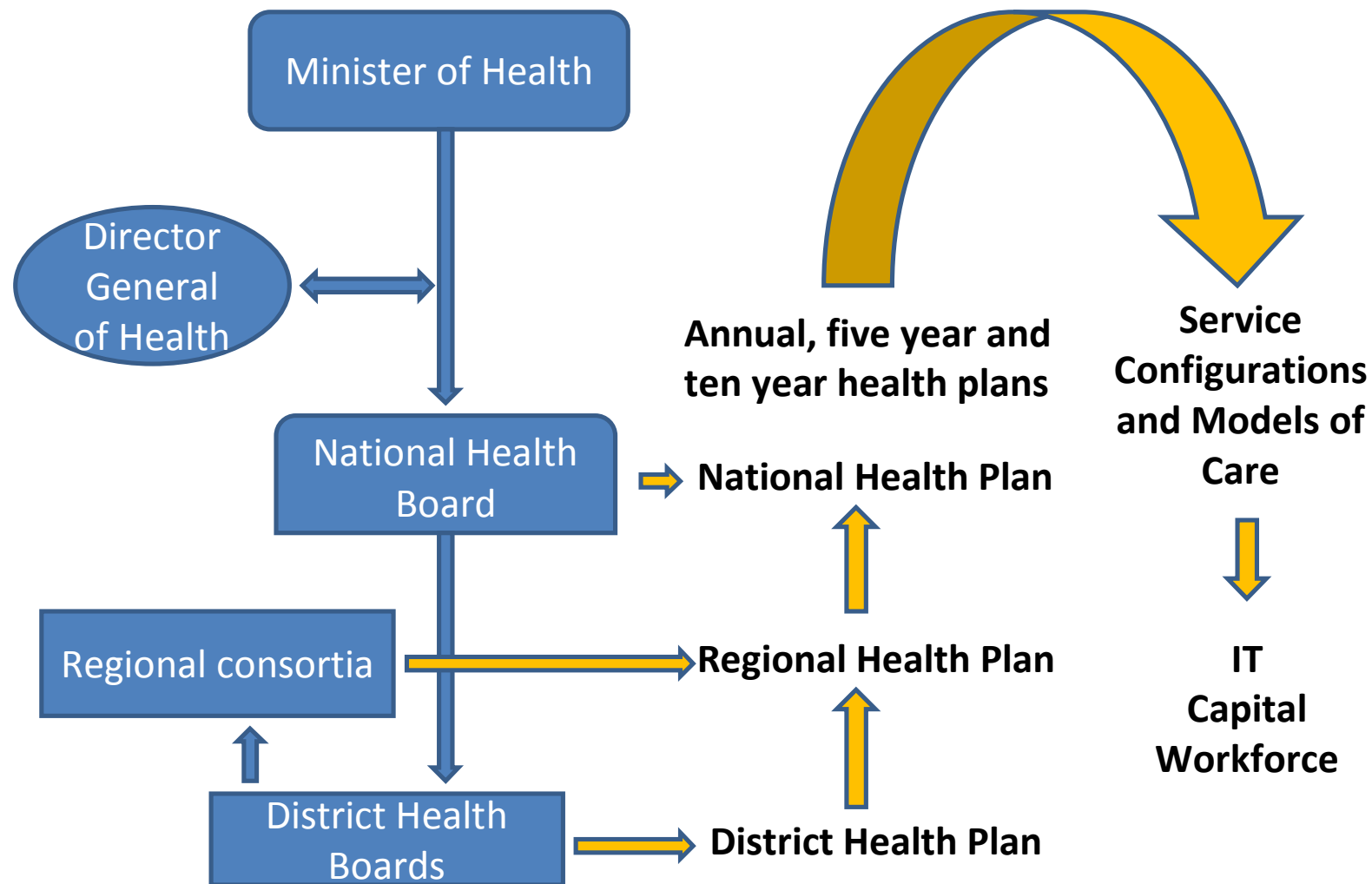
# **Towards a sustainable, diversified and fit for purpose health workforce**

- The way ahead - diversification of the New Zealand health workforce through intelligence, innovation and clinical leadership.
- A change in structure and establishing the correct relationship between a dog and its tail.
- The unification of health workforce planning and funding - Health Workforce New Zealand.

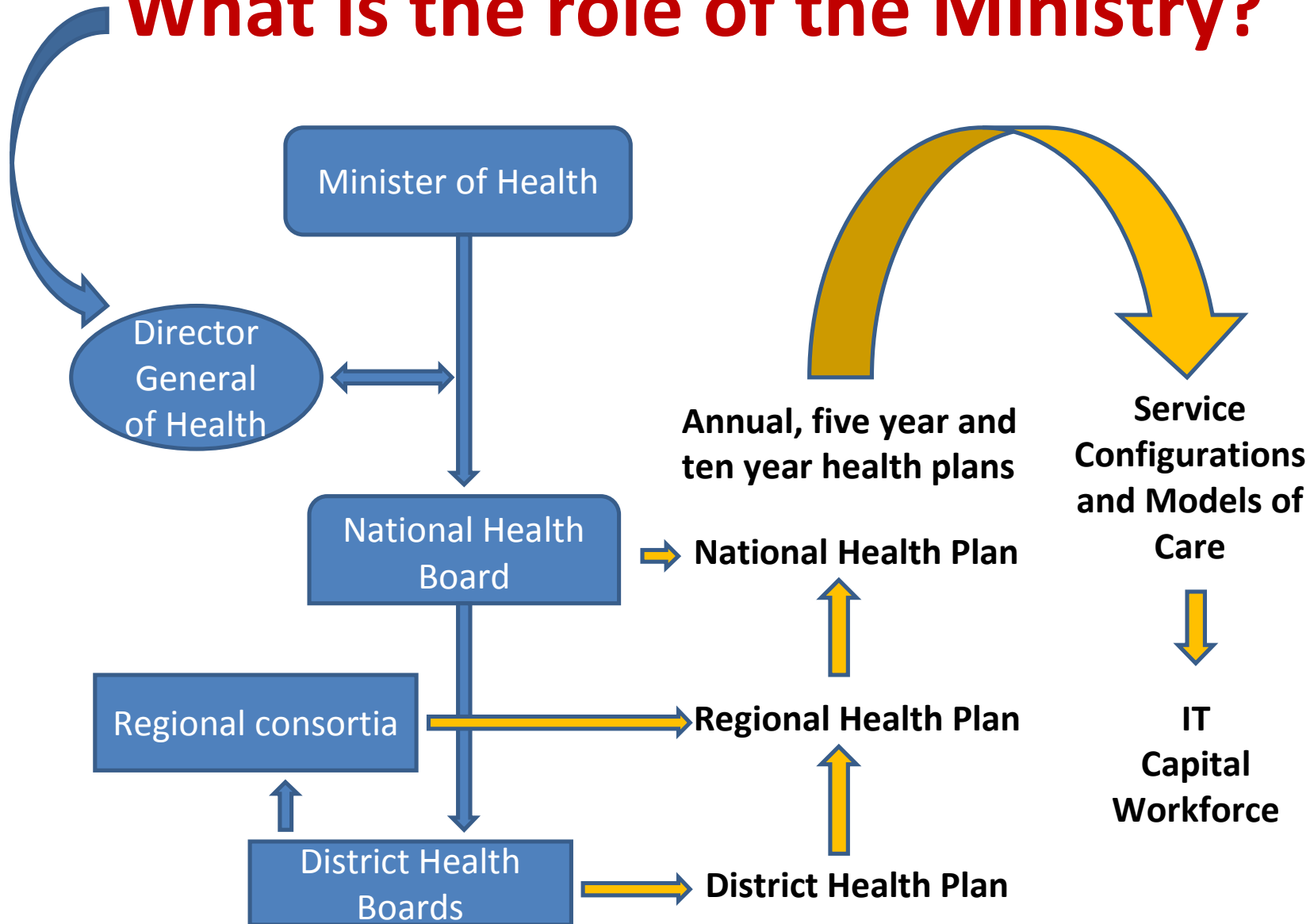
# Health Workforce New Zealand

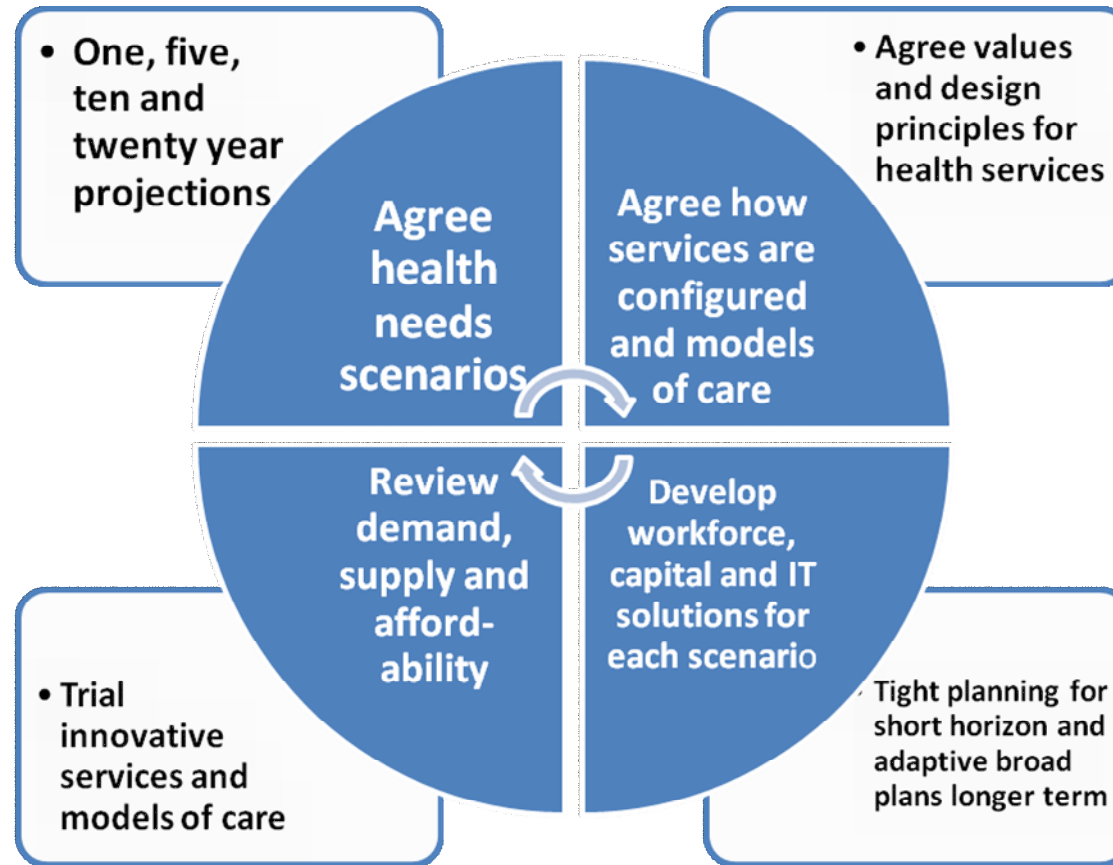
- A business unit in the Ministry of Health that reports directly to the Minister of Health and was formed by the Minister to consolidate activity and to lead the planning, funding, training and deployment of the health workforce.
- Mission is to ensure a fit for purpose and sustainable health workforce.
- Determination to have a whole of health workforce and whole of continuum view.
- Core values of intelligent planning, clinical leadership and innovative service configurations and models of care.

# The New Zealand Health System in 2010/11



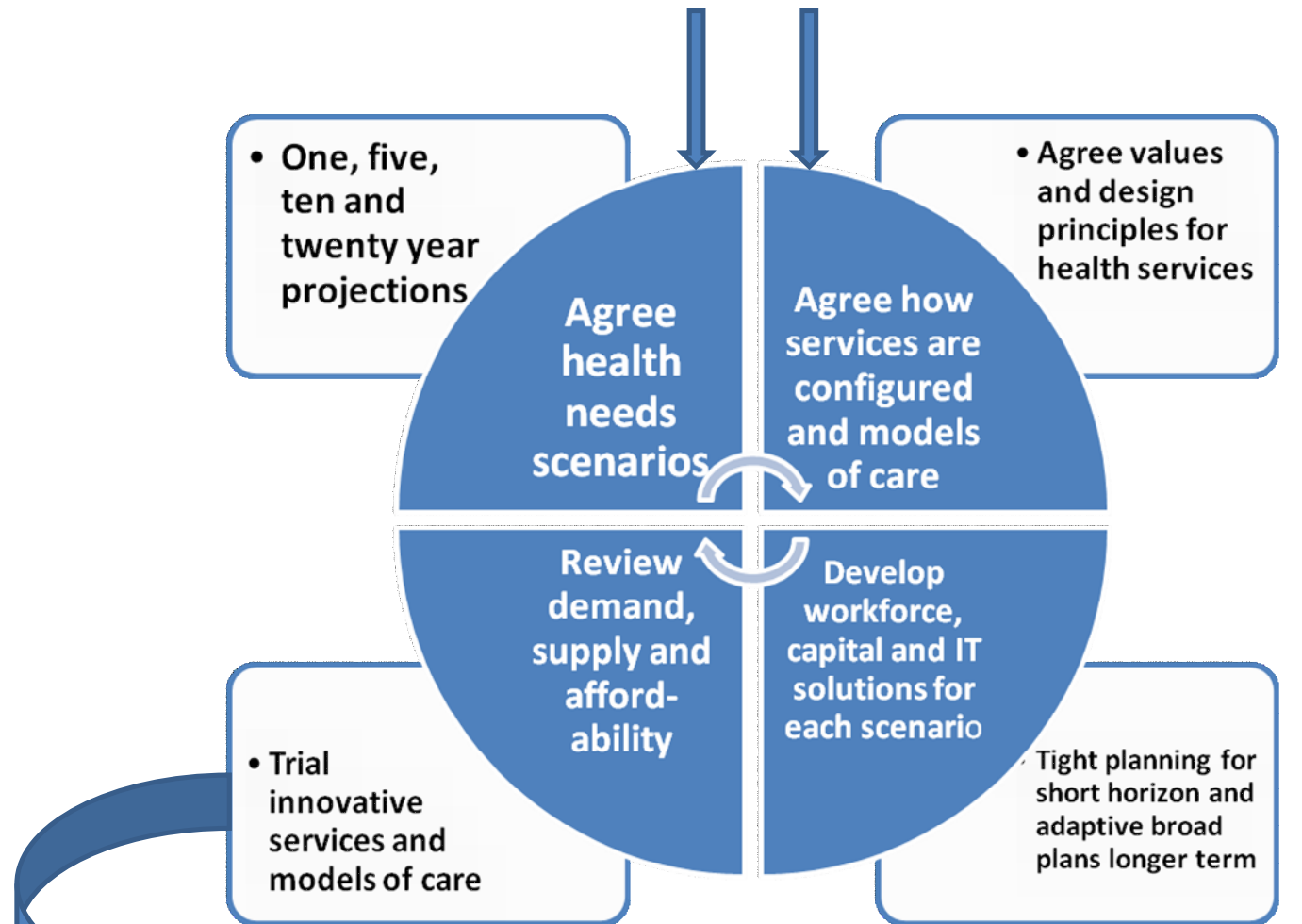
# What is the role of the Ministry?



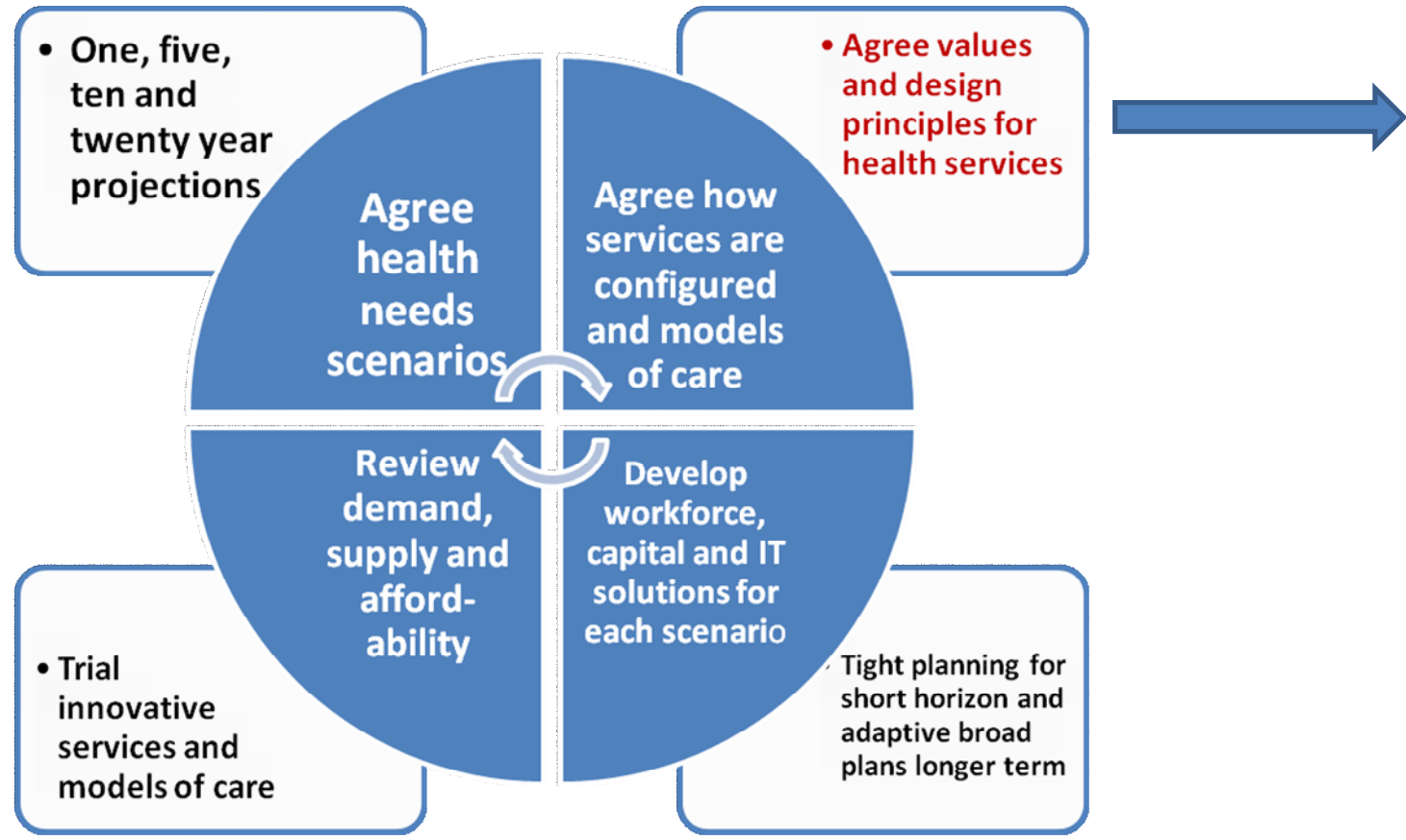




# Need for robust intelligence



**Revised configurations and models of primary care**  
**Extended scopes of practice for nurses and pharmacists**  
**Adoption of practice assistants**



# Agree values and design principles for health services

- Health care must be patient- and not practitioner-centred.
  - The use of an aggregate of “acceptable patient-journeys” to develop and evaluate services and models.
  - The broader application of *whanau ora*.
  - The adoption of international best-practice.

# Agree values and design principles for health services

- Health care will be largely delivered by way of health care teams that are integrated, multi-professional and where team leadership is both contextual and values-based.
  - Disruptive innovations as business as usual.
  - A sensible basis for role substitution and scope extensions, and the identification of remunerative and other barriers to rationalisation towards a trained and fit for purpose health workforce.

# Agree values and design principles for health services

- All health workers have clinical and corporate leadership responsibilities.
  - Use of the hidden curriculum of apprenticeship to develop the broader domains of professionalism.
  - An Institute of Health Leadership.
- The private health sector derives both direct and indirect benefit from Vote Health and consequently must also contribute to the broader domains of the New Zealand health service.

# Agree values and design principles for health services

- The New Zealand health workforce should look as much as is possible like the community it serves.
  - Selection processes (track students), affirmation and immersion.
- The New Zealand health system has to become increasingly New Zealand need-centric.
  - The Canadian role model.

# Agree values and design principles for health services

- The health system has to be sustainable and affordable.
  - “Slow to train” and expensive health workers should be retained in general scopes of training and practice as much as and for as long as is possible.
  - The health workforce needs to be incentivised in ways that encourages good practices.
  - The New Zealand health system should invest in and value career progression, training and status.

# Agree values and design principles for health services

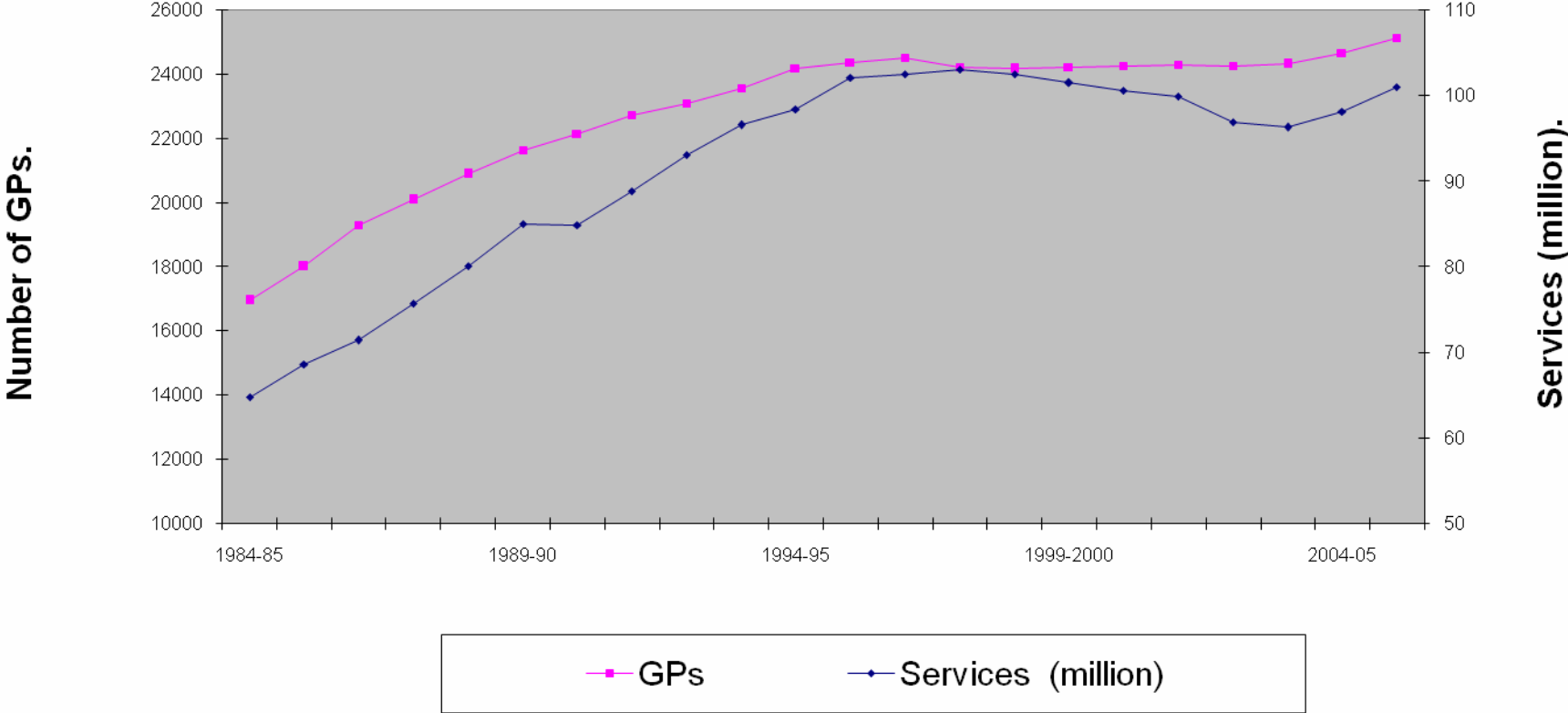
- The health workforce needs to be incentivised in ways that encourages good practices.
  - The necessity for sound policy settings that are grounded in clinical realities and that are appropriate for constructive monitoring and regulating.



# Relationship between GP numbers and services in the Australian fee-for-service health system

Dr Ian McRae (Australian National University)

GP Numbers and GP Services 1984-85 to 2005-06



# NZMC workforce survey data after the 2001 Primary Health Care Strategy

Figure 4: Average hours worked per week by work capacity at main work site

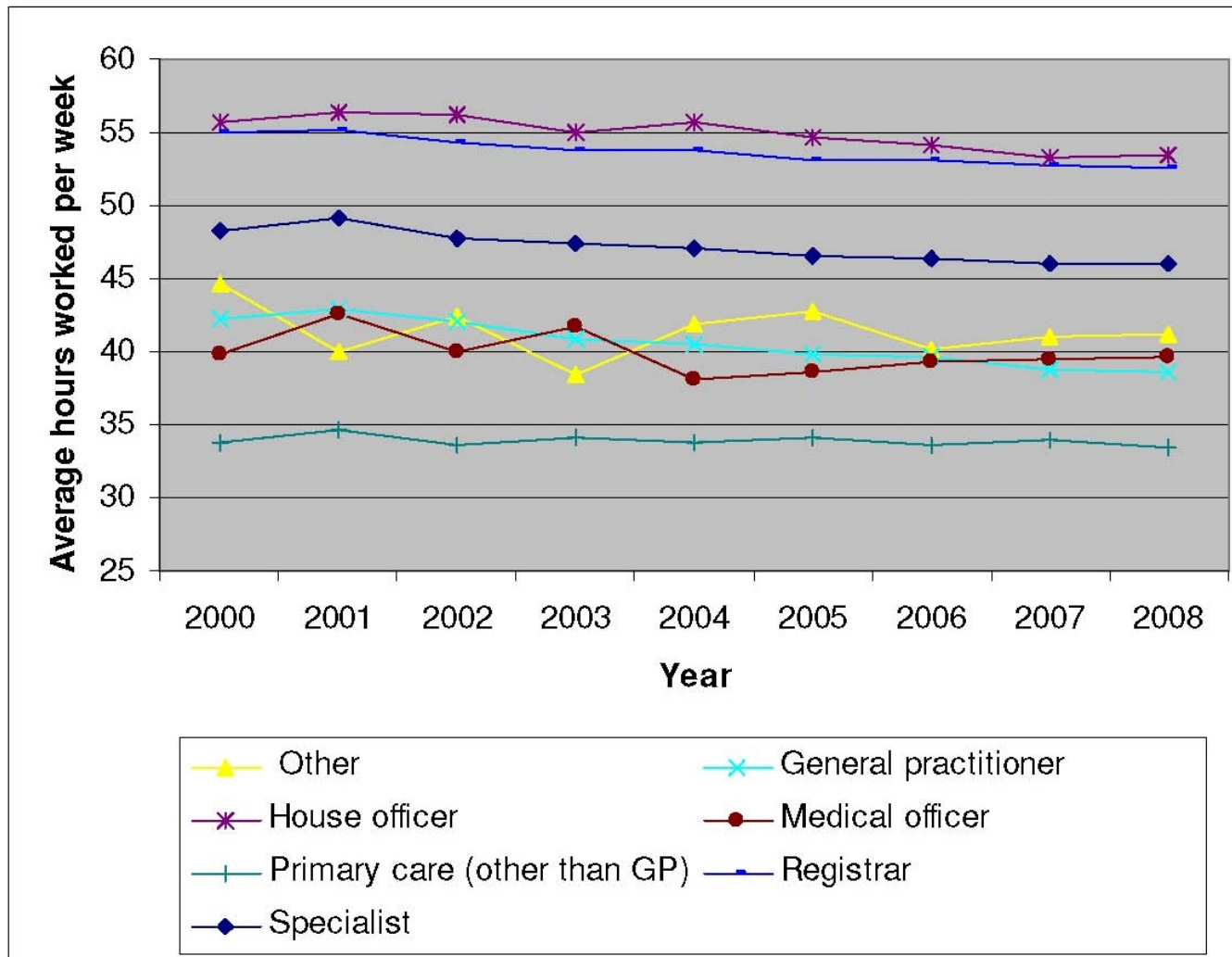
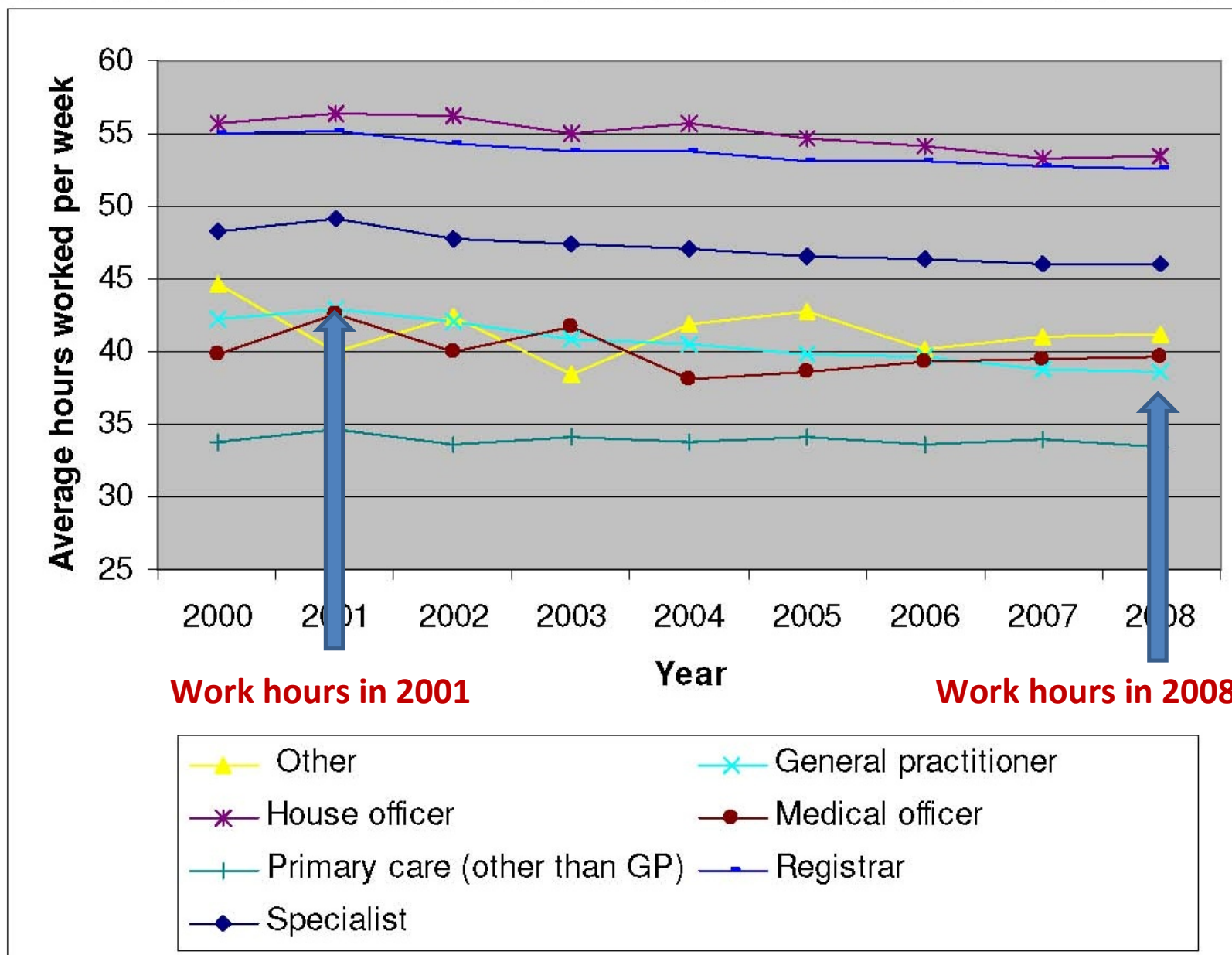
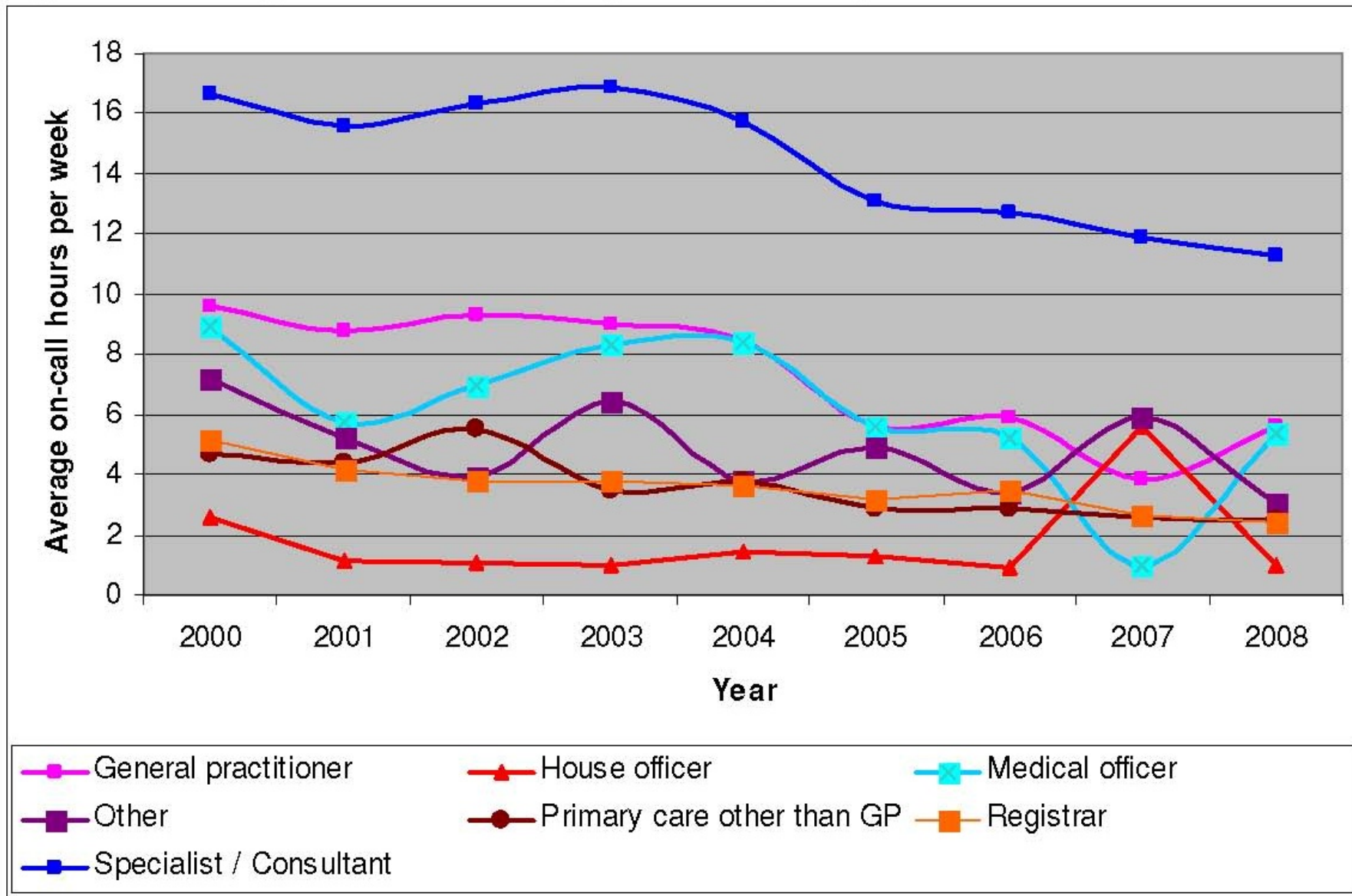


Figure 4: Average hours worked per week by work capacity at main work site

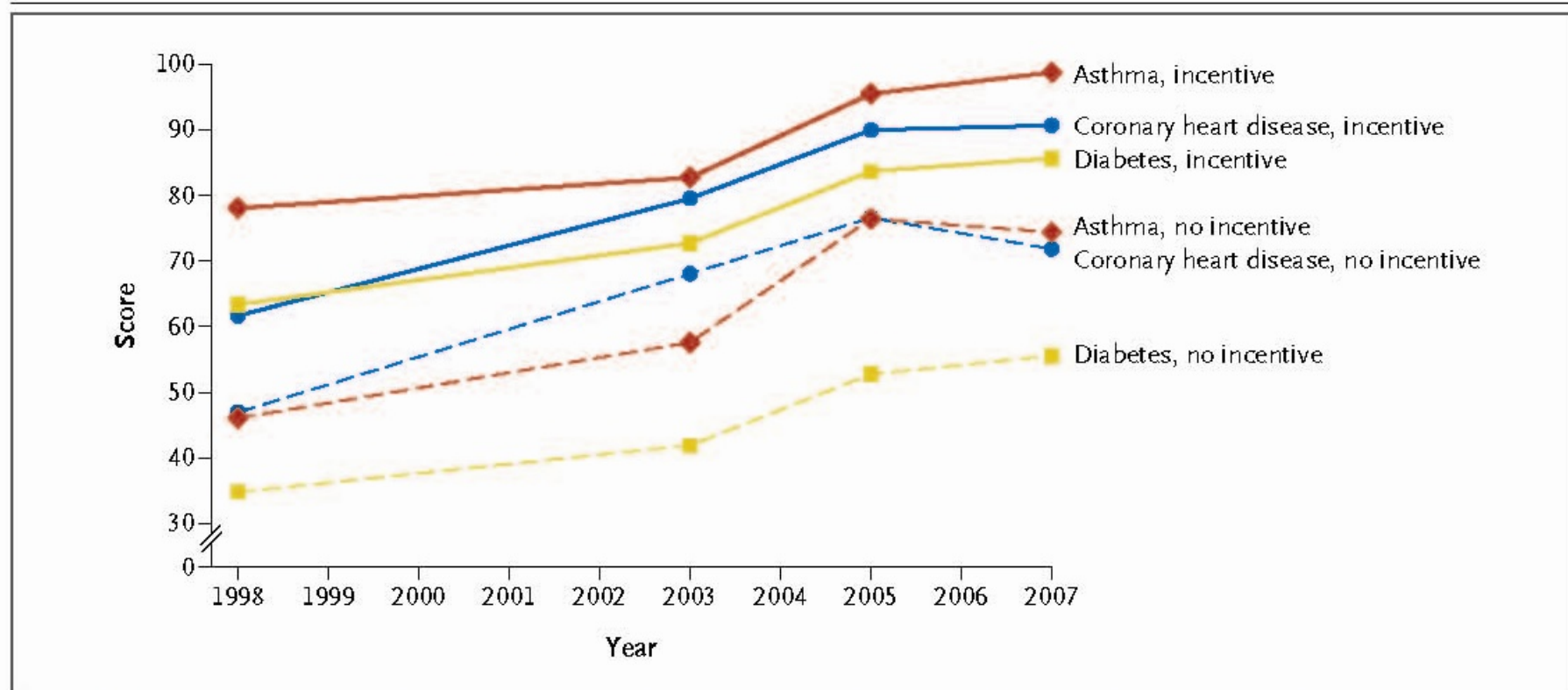


**Figure 6: Average on-call<sup>1</sup> hours, by work capacity at main work site**



<sup>1</sup> On-call hours are defined as hours when the doctor was on call, but not actually working.

**Campbell SM. Effects of pay for performance on the quality of primary care in England. NEJM 2009; 361: 368-78**



**Figure 2.** Mean Scores for Clinical Quality at the Practice Level for Aspects of Care for Coronary Heart Disease, Asthma, and Type 2 Diabetes That Were Linked with Incentives and Aspects of Care That Were Not Linked with Incentives, 1998–2007.

Quality scores range from 0% (no quality indicator was met for any patient) to 100% (all quality indicators were met for all patients).

# Agree values and design principles for health services

- The New Zealand health system should invest in and value career progression, training and status.
  - Differentiation from “unpopular” Australian States.
  - Enhancement of apprenticeships.
  - The Three-R’s scheme.
  - Voluntary bonding and special engagements.

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# Towards a sustainable, diversified and fit for purpose health workforce

- Interactive discussion of how primary health care is configured and how services are delivered
  - Saturday 12 June 2010 1100-55 and 1205-1300
- Community-based and integrated health care in 2020
  - Sunday 13 June 2010 1200-30