Health Workforce Funding Review - Current State Report

Public release copy

November 2020

Note: The attached report was prepared by MartinJenkins under instruction from the Health Workforce Directorate within the Ministry of Health. As such, any views expressed are not necessarily those of the Ministry.

While the report has been released in full, please be aware that the timeframes and project approach to the review have now changed. As such some of the information on page 45 (Next Steps) of the report is out of date but has been included for completeness.

The funding review will now become part of subsequent engagement that is likely to be required in response to the recommendations of the Health and Disability Systems Review.

Corrections and clarifications

The following are corrections and clarifications which were noted post the finalisation of the report

Page #	Correction/clarification
Page 40	Bullet one under 'Medical' should read: *Supporting an agreed number of trainees for vocationally registered general practitioners, other specialists, and post graduate trainees*

Last updated: 25 Nov 2020

MARTIN JENKINS

HEALTH WORKFORCE FUNDING REVIEW

Current State

September 2020

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PREFACE

This report has been prepared for the Health Workforce Directorate within the Ministry of Health by MartinJenkins (Martin, Jenkins & Associates Limited).

MartinJenkins advises clients in the public, private and not-for-profit sectors. Our work in the public sector spans a wide range of central and local government agencies. We provide advice and support to clients in the following areas:

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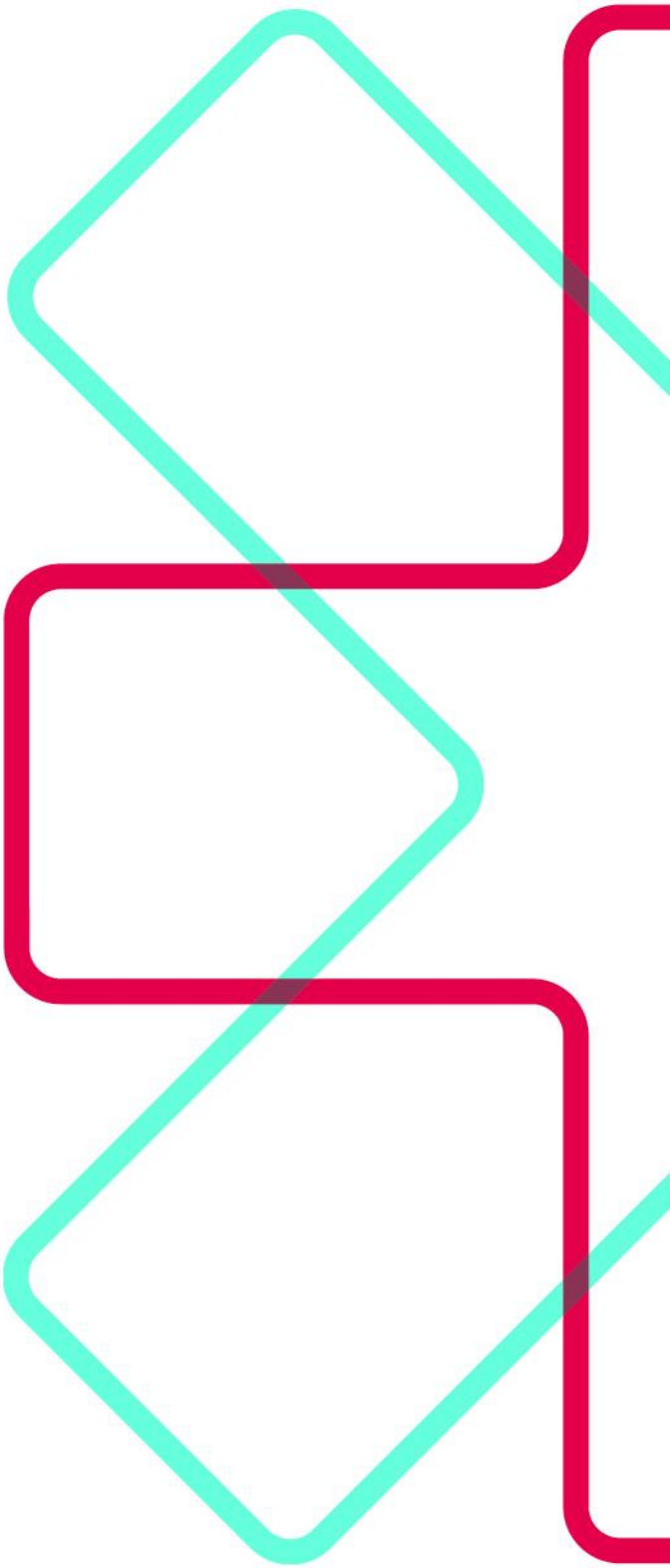
INTRODUCTION



Purpose of review

The current funding model has been utilised since HWNZ's inception and is largely based on the "Review of HWNZ training intentions 2012" and "What does Health Workforce New Zealand Buy (2011)" papers. It has been seven years since substantive changes were made to the Health Workforce Funding Model.

The Ministry of Health has commissioned MartinJenkins to undertake a review of current workforce training funding and investment across the system – with a view to providing options and recommendations for ensuring that funding is utilised where it is most needed and where it can make the most impact.

Background to review

In 1995 the Regional Health Authorities established the Clinical Training Agency (CTA) as an independent organisation to purchase Post Entry Clinical Training (PECT) for health professionals in New Zealand. CTA funding for vocational training was based on a cost compensation system.

In 2009/10, in response to Ministerial Review Group (MRG) recommendations on the future of the health and disability system in New Zealand and a need to shift away from rigid job definitions and work practices, the CTA was disestablished and workforce funding, planning and development responsibilities were transferred to Health Workforce New Zealand (HWNZ), a new group within the Ministry governed by the HWNZ Board. HWNZ was established to provide strategic leadership for a sector-wide response to workforce challenges, and became the primary provider of funding for post-entry clinical training.

In 2018/19, the HWNZ Board and group were disestablished and the Health Workforce Directorate, and a new Health Workforce Advisory Board, were established. The Health Workforce Directorate within the Ministry of Health invests in training and development of the health and disability workforce.

This funding:

- supports new graduate nurses, midwives, pharmacists and doctors to transition into the workforce in their first year of practice
- subsidises the costs of vocational (specialist) training for doctors including general practice trainees
- supports the postgraduate training of nurses, midwives and a range of allied health and scientific workers such as anaesthetic technicians, sonographers and medical physicists
- supports the training of the kaiāwhina workforce
- supports the Māori and Pasifika workforces.

The Health Workforce Directorate plays a key role in investing in workforce development. As it is not typically an employer of health providers, investment is one of the Ministry's few levers to influence the supply and operation of the health workforce. Effective investment is key to:

- ensure access to a skilled workforce that provides quality and safe healthcare
- ensure the workforce is responsive to system needs and shifting models of care
- address concerns about equity and population health outcomes
- ensure sustainability of funding.

Current operating environment

A review of the Health Workforce Development funding connects to impacts across the health and training system, including[1]:

- The Covid19 pandemic response will have wide ranging impacts on the health system. While the extent and detail of these are yet to be seen, the pandemic response may:
  - emphasise the need to have a strong understanding of the ability and likely training needs of the entry-level workforce
  - increase demand for telehealth services, including demand for associated skills and competencies
  - emphasise the need to focus workforce development activities to the areas of highest need
  - impact on the ability of training programmes to include overseas activities – including the largely shared workforce with Australia.
- The Review of the Health and Disability System and potential recommendations arising related to the structure of the health system and to the workforce. The interim report identified a number of issues related to the development of the workforce, including:
  - The workforce not reflecting the population it serves, with low participation from Māori and Pasifika
  - A need for stronger leadership
  - A need to respond to changing work types and demand for different skills – and a greater focus on acting in a more multidisciplinary way. This includes:
    - a tension between generalism and specialism
    - access to services in rural areas
    - training methods that have changed little in the past twenty years, which include a high reliance on supervision which may constrain system capacity.
- The Wai 2575 Inquiry by the Waitangi Tribunal, exploring persistent inequity of health outcomes for Māori.
- The Review of Vocational Education, with significant changes to the national approach to training. This includes the establishment of Workforce Development Councils (WDC's), which have key

[1] Ministry of Health, 'Health Workforce: Overview for discussion', Internal Slidepack, 12 October 2019

functions relating to qualifications and standards, setting skills leadership, and informing investment decisions by the Tertiary Education Commission.

The Government has indicated that there will be a WDC for Health, Community and Social Services. This WDC will play a key role in setting standards for the kaiāwhina workforce, including aged care, disability support, mental health and addiction, and social support services.[2]

Barriers and opportunities

The current funding model is heavily based on historical approaches. It has been seven years since substantive changes were made to the Health Workforce Funding Model. Investment is highly focused on subsidisation of supervision time. The amounts provided have not been adjusted for inflation and increasingly do not cover the true cost of training or supervisors' time.

This has led to concerns about equity – from both a population health perspective (Māori and Pasifika are significantly under-represented across the overall health workforce), and between workforces, with perceived higher levels of focus on investment in the medical workforce and consequently lower levels of investment in the nursing and other non-medical workforces.

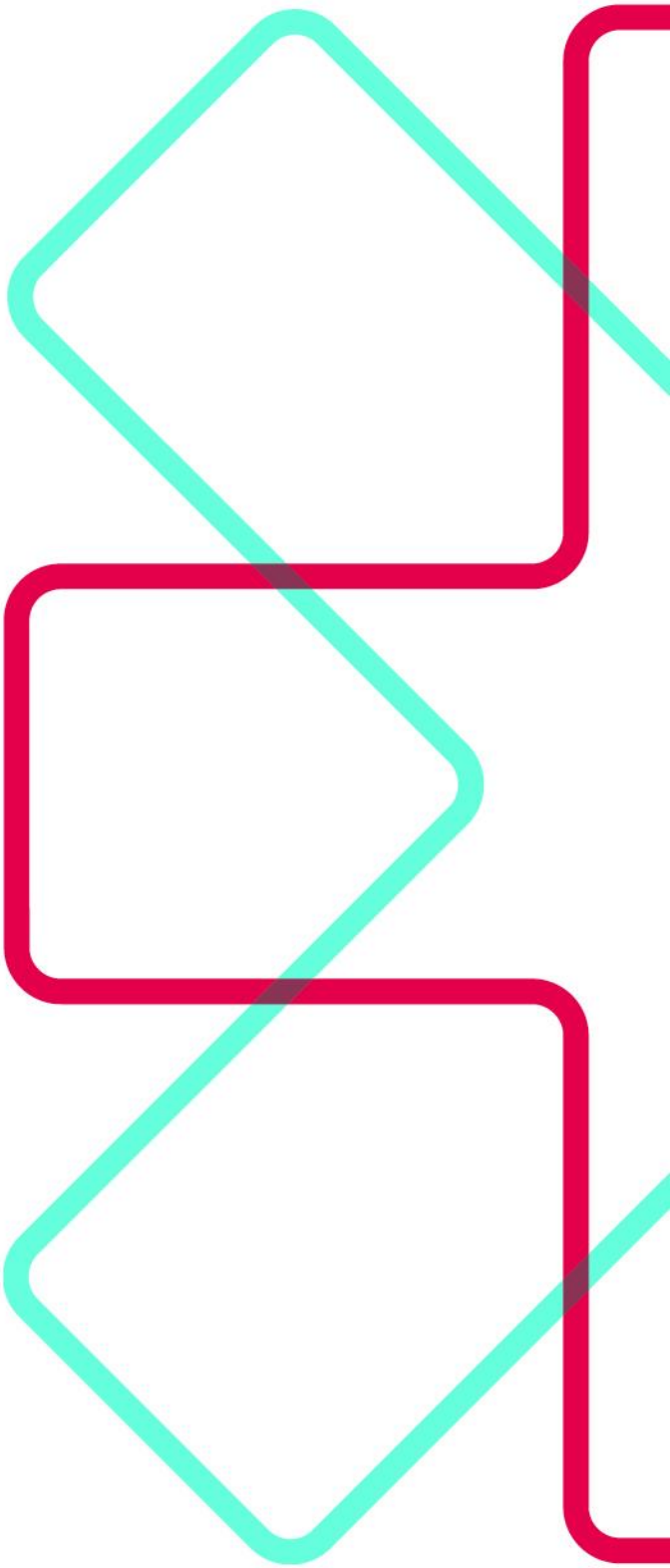
Health Workforce New Zealand made an attempt to shift to a more strategic approach to investment in 2017, through the development of an investment framework which would see a portion of its funding set aside each year for investment in strategic priorities based on an application process. The intent was well-received overall by the sector, although there were concerns about the clarity of processes for disinvestment to enable reinvestment in new areas. The proposal did not ultimately proceed due to a change in government and a shift in focus on health priorities.

The historic approach to investment means that there are many barriers to system change, including:

- The limited funding available does not meet the demand across all workforces. This limits the flexibility of Health Workforce to respond to shifting priorities or to address concerns of inequity or historical valuations
- There are concerns from workforces that a change in one area likely means a reduction in another, meaning that some programmes would need to be disinvested from
- As such, any funding increases over recent years have been due to individual budget bids targeting areas of priority for the day – funding specific programmes with defined targets and measures.

[2] While the scope of the WDCs is still being confirmed, it is likely that the health, community and social services WDC will replace the activities currently provided by Careerforce ITO, as well as some of those from the Skills Organisation and Funeral ITO. https://www.tec.govt.nz/assets/Forms-templates-and-guides/RoVE-WDC-Fact-Sheet.pdf

WORKFORCE SYSTEM



The health workforce system

Health and disability services in New Zealand are delivered by a complex network of organisations and people. Each has their role in working with others across the system to achieve better health for New Zealanders. A well-functioning health workforce system is integral to ensuring quality and safe health services are available to meet shifting demands for healthcare.

The healthcare workforce is at the centre of the system and includes those employed in the public health system, but also includes those employed in private healthcare. There are often connections between the two, with some professionals splitting their time, or moving between public and private.

The Health Workforce system can be conceptualised at a high level as including:

- Those that ensure quality health services. This includes oversight and regulatory entities such as the Ministry of Health, Health Workforce Directorate and Advisory Board, and regulatory authorities and vocational colleges.
- Those that provide training and development for the workforce. The supply of workforce can be driven by education providers, health service providers and training providers. It can also be driven by immigration of new workers from overseas and migration of existing workers overseas.
- Those that receive health services. This includes the entire New Zealand population receiving primary, secondary and tertiary services. Changes in population demand can be in part driven by aging population, demographic changes, and shifting population health requirements.
- Those that provide health services. Including District Health Boards (DHBs), and other private and NGO providers (for example pharmacists, laboratories, general practitioners, voluntary providers, community trusts, private hospitals disability support services).

Health workforce quality and safety

The Health Workforce comprises both regulated and non-regulated professions. The Health Practitioners Competence Assurance Act 2003 (the Act) provides a framework for the regulation of defined health practitioners in order to protect the public where there is a risk of harm from professional practice.

The Act sets out the workforces regulated under it, and defines the relevant Regulated Authority(s).[3]

The Health Workforce is governed by a range of actors with a variety of roles, several of which overlap.

- The Ministry of Health sets the overarching strategy for the health and disability system, and funds DHBs and other providers to deliver public health services

[3] There are also four additional workforces applying to become regulated workforces under the HPCA Act – Clinical Physiologists, Chinese Medicine, Cardiac Perfusionists, and Physician Associates.

- Health Workforce Directorate within the Ministry is responsible for stewardship of the overall health workforce, including workforce strategy, planning, and employment relations.

  The Directorate has invested significantly in health workforce modelling and analytic capability to understand supply and demand across key workforces.

  Investment in workforce training is one of the main levers that the directorate has to achieve its strategic objectives for the health workforce and respond to emerging or expected priorities. To help it perform its role, it works with:

  - Taskforces for each of the key workforces comprising representatives from across the health system, to advise on workforce pressures and priorities
  - The Health Workforce Advisory Board, a Ministerial advisory board that reports to the Minister on health workforce issues, including advising on workforce strategy, planning, and stewardship.
- Workforce Councils and Boards for the regulated professions, which are responsible for defining scopes of practice, education, training, and qualification requirements, and ongoing quality assurance
- Vocational colleges are responsible for the training, examination and recertification of medical practitioners in specific medical specialities or disciplines. They also provide ongoing medical education for specialists. Some colleges define the number of entry places in each vocational specialty, and as such have a significant impact on workforce planning. They also play a key role in defining scopes of practice. There are 15 colleges for the medical workforce, one each for nursing and midwifery, and several in the Allied Health workforce.

The Interim Report from the Review of the Health and Disability System has noted that: *"The large number of bodies leads to a lack of clarity about where responsibility sits and who is accountable for making sure the workforce pipeline is proactively managed over the short and long term. The boundaries between national, regional, and local planning are blurry, as are the responsibilities of the Ministry of Health, the Health Workforce New Zealand Committee, the Health Workforce Directorate, regional workforce development hubs, DHBs, universities, polytechnics, colleges, and employers."*

Health workforce supply

The number of New Zealand trained doctors and nurses registering has steadily increased over the last six years by on average 7% each year.

Universities, polytechnics, and other training providers provide initial training to large parts of the health and disability workforce, largely determining student numbers and curriculums except for medical training. The government sets the number of places that will be funded each year for medical training and provides a commitment to placing all New Zealand residents in house officer roles on graduation. From 2007 to 2015, the number of new medical training places increased from 342 to 539. The growth in number has placed pressure on Senior Medical Officer and Nursing workforces to provide cover and oversight of junior doctors, and on DHBs to provide sufficient levels of supervision-based training.

In 2018, around 21,000 people were studying for health-related bachelor degrees – nearly 17% of all students studying bachelor degree courses. The number of health students has been fairly consistent, at a time when the national number of domestic bachelor students has continued to decline.

Historically, New Zealand has been a net importer of workforce. International or overseas-qualified doctors (International Medical Graduates) and nurses (Internationally Qualified Nurses) make up a significant portion of the New Zealand health workforce. They are an important and valued part of the health system, bringing knowledge, experience and cultural diversity. OECD data shows that New Zealand's reliance on international or overseas-qualified doctors and nurses is high: 42% of doctors in New Zealand are overseas trained (the second highest in the OECD) and 26% of nurses (the highest in the OECD). There is at least two times as many registrations for international medical graduates in any given year than registrations for New Zealand trained doctors.

Some care settings rely more heavily on internationally trained health professionals than others. For example, in the aged residential care sector, about 44% of nurses are internationally qualified compared with 26% for all other settings (Health Workforce New Zealand 2017).

Doctors and nurses who come from overseas to work in New Zealand need to register here. Overseas trained doctors must apply to the Medical Council of New Zealand to verify their qualifications and may have to sit an English language test and a registration exam. Australian-trained nurses can automatically register in New Zealand and others are assessed by the Nursing Council of New Zealand against the requirements of the Health Practitioners Competence Assurance Act 2003.

People trained overseas in other regulated health professions also need to register with their relevant responsible body, such as the Pharmacy Council or the Medical Sciences Council of New Zealand.

Health workforce demand

Demand for health services is affected by key demographic characteristics such as the growth of the population as a whole, as well as age, the environment within which people live and other modifiable risk factors. Between 2013/14 to 2017/18, the largest growth in discharges was from medicine and mental health (13%, or an average of 3% per year). Population growth over the same period was estimated at around 8%.

The next 20 years will bring sizeable shifts to New Zealand's population in terms of age, ethnicity, and geographic spread. In addition to demographic shifts, environmental, social, technological, and cultural changes will provide both opportunities and pressures on the sustainability and efficiency of the health and disability system. In particular:

- New Zealand's population is projected to grow by almost 1 million people over the next two decades. Over half of this increase will identify with an Asian ethnicity
- An ageing population with a larger share of the population aged over 64, and a smaller share of the population aged under 30 in 2038. This trend is seen across all ethnic groups, but is most pronounced for the Asian population

- Based on current trends, the prevalence of obesity (diet and high BMI are the leading modifiable population risk factors) is set to continue to increase presenting significant health and societal challenges
- If not tackled comprehensively and early, the health and wellbeing consequences of poverty, racism, alcohol, emerging (and re-emerging) infectious diseases, climate change, changes to our urban environment, depletion of environmental resources, antimicrobial resistance, natural disasters, and the pressures of commercial drivers of poor health, poor mental health, and age-related conditions such as dementia will put significant pressure on our health system.

These changes will affect the health system from primary care right through to highly-specialised hospital care. These demographic circumstances are already leading to hospital demand outstripping supply.

As the proportion of the population ages, so too will the demands on the health and social system. People are living longer than previous generations, and they are living longer in poor health. This is particularly so for Māori, Pacific peoples, refugees, disabled people, and people living with a mental illness. Ageing is associated with an increase in long-term health conditions and multi-morbidities. Ministry of Health data shows that people aged 65 and older are more likely than younger people to be diagnosed with cancer or have a stroke, diabetes, heart disease, chronic pain, or arthritis.

The growth in demand for hospital and specialist services over the next 25 years as the population ages is dramatic. People aged over 65 are more likely to be admitted to a hospital, and to stay longer in hospital, than the total adult population. In 2018, people aged over 65 accounted for 15.8% of the total population, 34.5% of all acute hospital admissions, and 53.0% of acute bed days.

Ageing will affect each health service differently. In hospitals the largest growth will be in general medicine, orthopaedics, cardiology, and clearly age-related services such as assessment, treatment, and rehabilitation services, ophthalmology, and psychogeriatric services. Aged care, general medicine, and orthopaedic services will need to be able to deal with greatly increased numbers of patients. Hutt Valley DHB estimates that, with no other changes, by 2031 it will have growth of 38% in general medicine, 46% in cardiology, 49% in ophthalmology, 60% in assessment, treatment, and rehabilitation, and 71% in psychogeriatric services.

Demand for primary care services is also likely to increase due to ageing. Between 2008 and 2016, the number of GP consultations increased nearly 12%, which was slightly higher than the population growth of 10.2% in the same period. By ethnicity, growth in GP consultations was higher for Māori, Pasifika, and 'other' groups (27%, 29%, and 38%, respectively) compared with European New Zealanders (5%). Māori, Pasifika, and 'other' groups also had higher than average population growth. Changing demographics and a growing older population is relevant to understanding demand trends, as this group is likely to have the most ongoing and complex health needs.

WORKFORCE DEVELOPMENT

Current health workforce

The health and disability sector employs about 220,000 people or about 8.5% of New Zealand's total workforce – it is the single largest sector employer in the country. About 34% are employed by DHBs and 66% work in non-DHB roles, such as for private hospitals, residential homes for people with disabilities and rest homes.

The health workforce comprises around 150,000 people, of which roughly half are employed by DHBs. Some professions – such as general practitioners, chiropractors, osteopaths, psychotherapists, and dentists – work mostly in private practice. In many places, the DHB is among the largest employers in the region. In addition, volunteers and unpaid family and whānau carers play an important role in the health and disability system.

Clinical staff (staff engaged directly in the care of people) make up 66% of the health and disability workforce. Personal carers and assistants (23% of the workforce) and nurses and midwives (21%) are the largest groups and the medical group is the smallest (6%).

There is limited workforce data available for the non-regulated professions, which limits policy development, particularly within mental health and addiction areas, aged care and disability. The Ministry of Health will be investigating ways to gather better information on these workforces in 2020/21.

Table 1: below sets out the size of each respective health workforce. The size, composition and distribution of the kaiāwhina workforce, the non-regulated allied health workforce (such as counsellors and audiologists), paramedics, medical technicians and health and welfare support workforces are currently much more difficult to determine due to unavailability of data.

Table 1: Headcount for Professional Areas of the Workforce

Professional Area	Headcount
Medical	15,761
Nursing	55,289
Midwifery	3,023
Allied Health (regulated professions, broken down below)	28,347
• Occupational therapy	2,294
• Optometry and optical dispensing	856
• Physiotherapy	4,906
• Anaesthetic technology	708
• Pharmacy	3,577
• Dietetics	660
• Medical laboratory science	3,323

Professional Area	Headcount
• Chiropractic	580
• Psychotherapy	512
• Medical radiation technology	3,002
• Osteopathy	432
• Psychology	2,640
• Podiatry	399
• Dentistry and dental therapy, hygiene or technology	4,458
Allied Health – non-regulated professions	~15,000
Care and support workforce	~55,000

Source: These numbers, other than those for care and support workers, are based on the relevant responsible authority's workforce report for 2017. Care and support workforce numbers are an estimate from the Ministry of Health Regulatory Impact Statement for the Negotiated Settlement for Care and Support Workers (2017). Allied Health non-regulated professions are an assumption based on an overall Allied Health Workforce estimated at 43,000 (MOH Commissioning Team).

There are also cross-cutting workforces. For example, the Mental Health workforce spans the medical, allied health, nursing, and non-regulated professions. A stocktake by Te Pou in 2018 estimated that the workforce comprised 10,831 FTE (which would be approximately 7% of the total health workforce). The stocktake estimates that over half of the adult mental health and addiction workforce was in clinical roles (53 per cent) including nurses (30 per cent), allied health (16 per cent), and medical practitioners and other clinical roles (7 per cent). One-third (34 per cent) of the workforce was in non-clinical roles, and 13 per cent was in administration and management roles.

Characteristics of health workforce

The health workforce faces a number of key challenges:

Māori and Pacific practitioners are significantly under-represented. In spite of increasing numbers of Māori entering health professions, only 3% of doctors, 7% of nurses, 2% of pharmacists and 10% of midwives are Māori (Ministry of Health 2018). Similarly, Pacific people comprise 7.4% (Statistics NZ) of the population, yet only 2% of doctors (Medical Council of New Zealand, 2016) and 4% of nurses (The Nursing Council of New Zealand 2018) are of Pacific descent. Services: Mental health, Disability support.

Distribution & Access: Rural Geographic maldistribution of the workforce. This is a challenge particularly for primary care and rural and provincial hospitals, which can struggle to recruit and retain the specialists they need. In general, job applicants and trainees tend to favour large cities, particularly Auckland.

Low levels of health professional retention within New Zealand with serious impacts on the sustainability and productivity of the health workforce. Approximately 28% of international medical

graduates and 12% of New Zealand medical graduates no longer practice in New Zealand after five years (Ministry of Health, 2018). This represents a loss of prior Crown investment in training (for the New Zealand trained medical graduates) but also places greater pressure on other practitioners to manage workloads.

An ageing workforce. A little over 40.1% of doctors were aged 50 or over in 2015, up from 35.3% in 2009. Six years ago the largest group of doctors was aged between 45 and 49. Since 2011 the largest group has been 50-54 year olds (Medical Council of New Zealand, 2016).

Health workforce development

The responsible authority for each profession defines the 'scope of practice'. A scope of practice may include reference to common tasks performed by the profession; an area of science or learning within the profession; references to names and words commonly understood by those working in the health sector; and reference to illnesses or conditions to be diagnosed, treated or managed by the profession.

Only practitioners registered under a scope of practice may use the title associated with their scope. The HPCA Act specifies registered health practitioners registered with a particular authority must not perform activities that fall outside the scope of practice for which they are registered.

Setting workforce progression and training standards

From an education and qualification perspective, key functions include

- prescribing qualifications required for the profession's scopes of practice, and accrediting and monitoring educational institutions that teach and award/confer these qualifications
- considering applications for annual practising certificates
- recognising, accrediting and setting programmes to ensure the ongoing competence of health practitioners
- promoting education and training within the profession.

Managing quality assurance

The Authorities are also responsible for managing competency and quality assurance of professionals, including:

- setting standards of clinical competence, cultural competence and ethical conduct to be observed by health practitioners
- reviewing and promoting the competence of health practitioners
- receiving and acting on information from concerned parties about the competence of health practitioners, and in turn notifying the relevant authorities if a health practitioner poses a risk of harm to the public
- considering the case of a practitioner who may be unable to perform the functions required for the practice of the profession.

Each workforce has different development standards and requirements, typically defined by an occupational regulatory authority such as those defined under the HPCA Act (and set out in section 4 above). In many cases, education and training requirements are set by Colleges and endorsed by Councils. The majority of health professional courses include clinical placements predominantly in DHBs. Access to suitable placements has been cited by some as a constraint that limits the number of places offered in undergraduate degrees.

Medical

Prevocational training

All graduates of New Zealand and Australian accredited medical schools undertake prevocational medical training, also known as the intern training programme. It is also undertaken by doctors who have obtained registration based on a pass in the New Zealand Registration Examination (NZREX Clinical). Training for interns typically spans two years across postgraduate year 1 and postgraduate year 2.

The intern training programme is aimed at enhancing and refining the clinical and professional skills they have gained at medical school. The Council accredits DHBs as training providers for interns. Accredited DHBs assign to each intern a Prevocational Educational Supervisor, a vocationally-registered doctor appointed by the Council, who will oversee their overall educational experience.

Vocational training

After completing prevocational training (including in most instances two to three years of postgraduate experience) and achieving general medical registration recognised by the Medical Council of New Zealand, trainees can choose to apply to enter a training programme in a specialised vocational area.

There are 36 areas of medicine, or 'vocational scopes' which are recognised by the Medical Council of New Zealand. These are areas of specialised medical practice, each defined by an accredited postgraduate training programme and qualification. Vocational registration is a form of permanent, specialist registration which allows doctors to work independently in New Zealand. To enter one of the training programmes medical colleges require an applicant to be a graduate in Medicine and Surgery of a Medical School recognised by the Medical Council of New Zealand.

Once a trainee completes their training programme, they become a fellow of their medical college and are expected to participate in Continued Professional Development activities, which contribute to their ability to be recertified annually by the Medical Council of New Zealand.

Nursing

The Nursing Council accredits educational institutes that have undergraduate nursing programmes, return to practice Competence Assessment Programmes and post graduate courses. The Council also sets the requirements for registration within three specific scopes of practice in New Zealand.

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- Enrolled nurse - enrolled nurses generally practise under the direction and delegation of a registered nurse or nurse practitioner to deliver nursing care and health education across the life span to health consumers in community, residential or hospital settings
- Registered nurse - the Nursing Council has amended the registered nurse scope of practice to indicate that some registered nurses can prescribe prescription medicines. There are two levels of prescribers – Registered Nurses prescribing in primary health and specialty teams, and Registered Nurses working in community health. These roles have different qualification and prescribing lists.
- Nurse practitioner - nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practise beyond the level of a registered nurse. Applicants for registration as a nurse practitioner must complete a Nursing Council accredited master's degree programme (a structured programme of clinically focused taught courses) and undergo a Nursing Council assessment before registration.

Nurses are expected to maintain the required standard of competence to protect public safety. This includes the need to maintain an Annual Practicing Certificate (APC) from the Nursing Council. Maintaining an APC requires nurses to complete 450 practice hours and 60 hours of professional development (both over a three-year period).

Allied Health

Allied Health professionals are university qualified practitioners with specialised expertise in preventing, diagnosing and treating a range of conditions and illnesses. There are more than 40 Allied Health professions. A list is set out in Appendix 1. They work in diverse settings including: primary care, secondary care, community health hubs, PHO's, private health clinics, schools, correctional facilities, maraes, hospices, health promotion, health NGO's, disability services, aged care facilities and sporting organisations, and as such, have different development standards and requirements.

There are 27 national allied health associations that have different requirements for ongoing training and professional development. For professions that are regulated under the HPCA Act, training must align with responsible authority requirements. Where a profession is not regulated under the HPCA Act, training may be required to meet requirements set by other specified non-statutory registration or professional bodies.

As set out in the previous section, each regulatory authority defines their own scopes of practice for each profession, prescribes qualifications, accredits and monitors educational institutions, considers applications for annual practising certificates, reviews and promotes the competence of health practitioners, and promotes ongoing education and training within the profession. This can often be in the form of post graduate diplomas, evidence of achieving a minimum number of hours of clinical experience in the chosen scope of practice, and providing some form of evidence of enrolment and participation in a Board-approved recertification programme (commonly referred to as a CPD programme).

Midwifery

The Midwifery Council is the regulatory authority set up to guard professional standards in midwifery to make sure midwives meet and maintain professional standards of education, conduct and performance so that they deliver high quality healthcare throughout their careers. Pre-registration midwifery education programmes are four-year Bachelor degree programmes. They are designed to prepare students for registration and practice as a midwife in New Zealand.

Following pre-registration, midwives must obtain a Practising Certificate to demonstrate that they meet required competency standards. Midwives typically undergo an annual recertification programme, and a midwifery-standards review every three years.

Kaiāwhina

Due to its unregulated nature, there are limited post-entry requirements for Kaiāwhina workers. In recent years there has been an increased focus on career development, including creating and clarifying career pathways, and developing leadership skills and transferable skills through the Kaiāwhina Workforce Action Plan. An indicative list of Kaiāwhina roles is set out in Appendix 2.

Analysis of data collected in 2017/18 and 2018/19 on care and support workers shows that:

- there has been a significant increase in support workers with qualifications in the home and community support, disability, and mental health and addiction sectors
- support workers with higher qualifications deliver relatively more hours of care than unqualified workers
- there are a number of workers with no qualifications who are paid based on their length of service, and are therefore unlikely to take up training opportunities.

Careerforce is the industry training organisation for the health, mental health, aged care, disability, and social services workforce. Qualifications such as the New Zealand Certificate in Health and Wellbeing can be gained at relatively low cost, without university study. These qualifications can form the basis for certification in many healthcare, disability support, aged care, home and community support, and social services positions.

Workforce development providers

For the regulated workforce, workforce development requirements are set out in the scopes of practice and registration requirements are determined by the regulatory authorities. Ongoing professional development is often a key requirement for ongoing membership of a vocational college.

Admission to a college is largely an apprenticeship-based education model, with training organised by the colleges, but occurring within a DHB setting.

Funded providers include:

- DHBs which coordinate training of many of the workforces - including medical and nursing post graduate training, as well as medical and specific allied-health vocational specialisations. DHBs are expected to maintain accreditation with the relevant accrediting body

- Royal New Zealand College of General Practitioners and the New Zealand College of Midwives for programmes related to their workforces (which are not provided by DHBs)
- A range of non-DHB entities which provide a small number of specified services.

The non-regulated workforce has a range of workforce development provision, including:

- Careerforce, the industry training organisation, which organises a range of workforce development and training for the aged care, disability support, mental health and addiction, and social support services, particularly levels 1-6 of the NZQA framework. Careerforce do not facilitate or deliver training and are contracted to manage the grant process and its delivery. Careerforce Apprenticeship Advisors (Advisors) work closely with employers and trainees undertaking the qualifications in the area of Health and Wellbeing – Mental Health and Addiction.
- NGO providers which deliver targeted workforce development, for example for the mental health workforce (including the Workforce Centres such as Te Pou, Te Rau Ora, Werry Wharaurau and Le Va).

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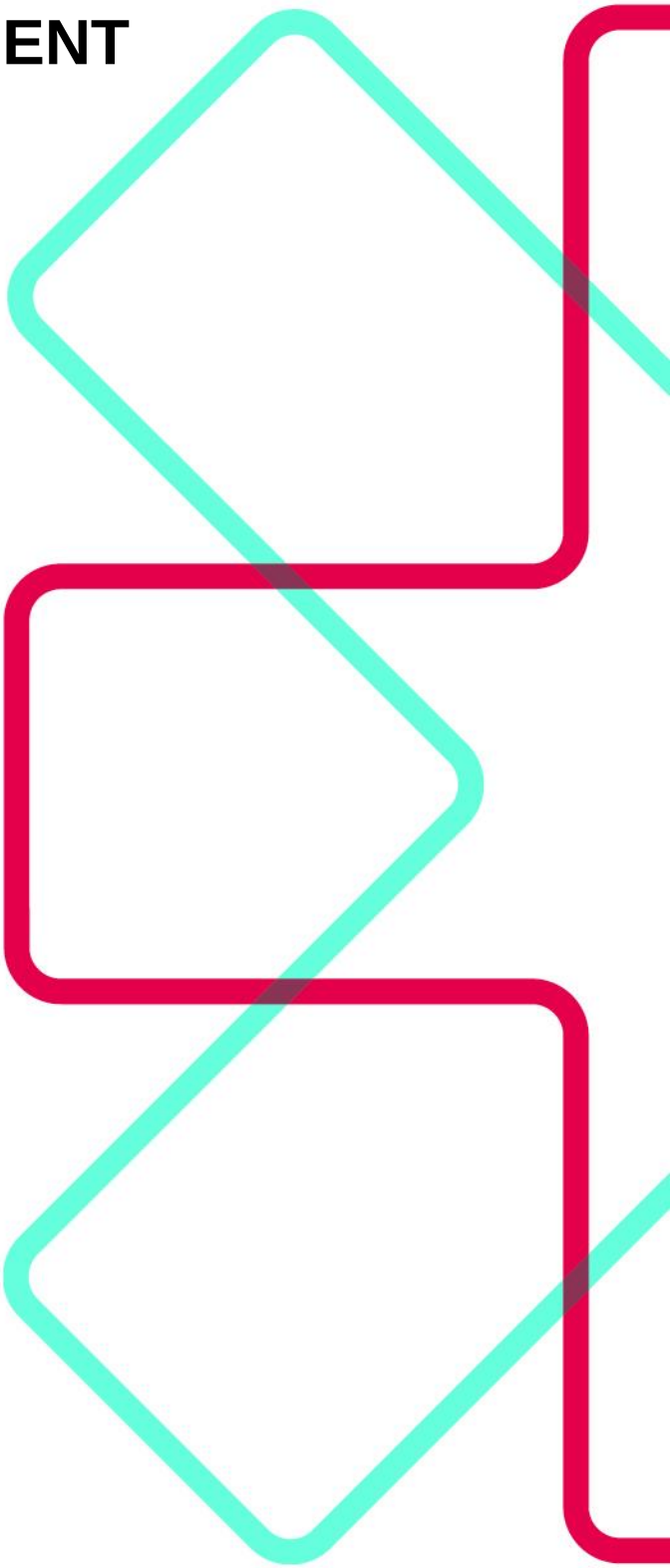
WORKFORCE INVESTMENT



Funded workforce development in 2019

In Budget 2018, Health Workforce received a non-departmental appropriation for Health Workforce Training and Development of $186.7 million.

Due to the requirements for ongoing professional development, a large proportion of the workforce is undertaking training or development activities. This includes core training requirements (to meet occupational regulation requirements), training in specialised vocations, and ongoing professional development.

In 2019, nearly 14,000 people undertook some form of funded workforce development activity, as set out in the table below.[4]

Table: Participation in Health Workforce training (2019)

Workforce category	Count	Proportion
Medical	2,938	21%
Nursing	2,741	20%
Allied Health	384	3%
Midwifery	1,161	8%
Mental Health	3,767	27%
Disability	1,468	10%
Māori	1,076	8%
Pasifika	96	1%
Voluntary Bonding Scheme	357	3%
Total	**13,988**	

Source: Ministry of Health

This investment results in a per-person average which varies significantly across workforces, as set out in the table below.

Table: Health Workforce Investments – Average per individual (2019)

Workforce category	2019 actual spend	Count	Proportion
Medical	$114.3m	2,938	$38,896

[4] Numbers have been broken down by the different work streams and, for example, the number of Māori being funded through Health Workforce will be higher than 1076 (which refers only for Māori Support Funds, and Hauora Māori Funds).Numbers for categories such as Mental Health also include the number of people attending workshops (hence the high numbers compared to other areas)

Workforce category	2019 actual spend	Count	Proportion
Nursing	$21.2m	2,741	$7,746
Allied Health	$5.6m	384	$14,523
Midwifery	$6.3m	1,161	$5,433
Mental Health	$22.7m	3,767	$6,029
Disability	$3.0m	1,468	$2,056
Māori	$2.7m	1,076	$2,544
Pasifika	$0.08m	96	$790
Voluntary Bonding Scheme	$7.6m	357	$21,200
Other contracts	$1.2m	N/A	N/A
Total	**$184.7m[5]**	**13,988**	

Source: Ministry of Health

Careerforce estimates that across New Zealand more than 12,000 support and care workers are undertaking workplace training annually.

Health workforce investment in 2020

In Budget 2019, Health Workforce received a non-departmental appropriation for Health Workforce Training and Development of $213.47 million, or 1.1% of Vote Health.[6] This was an increase of $24.5m from 2018/19, due to an increase of:

- $13.888 million for the Budget 2019 initiative Expanding Access and Choice of Primary Mental Health and Addiction Support
- $6.133 million for the Budget 2019 initiative Nursing Workforce Accord - Providing Additional Places for Nurse Entry to Practice, and
- $4.563 million for the Budget 2019 initiative Health Workforce Training and Development to Benefit Rural and Regional Areas.

The appropriation is limited to the provision, purchase, and support of workforce development for people working in the health and disability sector and of services that support those workforces to be sustainable, flexible, and fit-for-purpose.

A breakdown of how the funding is allocated across workforces is set out in the table below.

The funding is invested through DHBs and other providers and supports in-work post-graduate training of recent-entrants into the workforce, for example part-funding the costs of supervision for

[5] The difference against budget was carried over to 2020 for Health Workforce Development (Innovation).

[6] https://treasury.govt.nz/sites/default/files/2019-05/est19-v6-health.pdf p.2

non-registered medical staff. Other providers include NGOs, Māori and Pacific health providers, research institutes and some private sector providers.

While there is not a specific line item for investment in the kaiāwhina workforce, kaiāwhina workers receive investment through other funds, for example those targeting mental health and disability support workers (which include large numbers of care and support workers), as well as funding specifically to support Māori kaiāwhina workers.

Table: Health Workforce Investments (2020)

Workforce Investment	Amount (2020)	Proportion
Medical	$119.42m	55.9%
Nursing	$28.43m	13.3%
Allied Health	$6.87m	3.2%
Midwifery	$5.31m	2.5%
Mental Health	$36.51m	17.1%
Disability	$3.04m	1.4%
Māori	$2.75m	1.3%
Pasifika	$0.15m	0.1%
Voluntary Bonding Scheme	$6.92m	3.2%
Other contracts	$4.07m	1.9%
Total	$213.47m	100%

Source: Ministry of Health

Detailed workforce investments 2020

Medical (119m, 56% of total cost)

The Health Workforce Directorate funds DHBs and other organisations, such as the Royal New Zealand College of General Practitioners (RNZCGP), for postgraduate clinical training.

The investment in the medical workforce comprises two main types:

- Support to transition new medical workforce to meet the needs for registration. Subsidies to DHBs for the costs to train House Officers (Post Graduate Year 1) and Registrars (Post Graduate Year 2).
- Subsidising the cost of vocational (specialist) medical training., including Internal Medicine, Anaesthesia and Intensive Care, Surgery, Emergency Medicine, Psychiatry, Obstetrics and Gynaecology, Diagnostic and Interventional Radiology, Pathology, Radiation Oncology, Ophthalmology, Rural Hospital Medicine, Dermatology and Palliative Medicine. There is a potential disconnect between contracted volumes per specialty and the number of DHB

employed registrars. The Ministry notes difficulty prioritising training for different specialties due to not being the employer.

Health Workforce primarily contracts with DHBs, identifying an agreed number of participants at each level and specialty. Contracted amounts are based on a set subsidy rate, depending on the programme or specialty:

Medical training also includes a number of specific contracts, including

- contracting directly with the Royal New Zealand College of General Practitioners to undertake the General Practitioner Education Programme, which includes provision for enrolling and training 184 General Practitioner (GP) registrars.
- provision for the Clinical Education and Training Unit, which provides coordination for the provision of training within a clinical setting
- investments to support multi-disciplinary medical training in rural areas
- other contracts with non-DHB providers for targeted training needs.

Nursing ($28m, 13%)

Health Workforce funds training and workforce development for DHB employed nurses and newly registered nurses. . Training must align with Nursing Council requirements.

Health Workforce contracts with the 20 DHBs. DHBs are responsible for prioritizing appropriate postgraduate nursing training programmes in accordance with workforce needs and strategic plans. Funding is focused on two main areas:

- Undertake post-graduate nursing qualifications to support nurses to work to the top of their scope of practice and lead to roles such as clinical nurse specialists. This investment is intended to help address health workforce pressures and support greater cross-disciplinary practice. This is approximately $13.7m or 48% of the total.
- Provide transition support for registered nurses into Nursing Entry to Practice programmes. This is approximately $14.8 million (including $6.1 million of additional funding from Budget 2019), equivalent to 52% of the total. NETP programmes are for newly registered nurses, undertaking study to Level 2 in the Professional Development and Recognition Programme framework approved by the Nursing Council New Zealand. Funding is available for 1290 places, while approximately 1800 new graduate nurses have registered each year over the past five years.

Health Workforce also provides support for a small number to work towards the Nurse Practitioner programme.

Allied Health ($6.87m, 3.2%)

Allied Health covers more than 40 professions, and around 43,000 workers. Professions vary significantly in size, but tend to be small and as such can be vulnerable.

- Health Workforce contracts with DHBs to subsidise the costs to train some specified allied health professions, including Anaesthetic Technicians, Cardiopulmonary Technicians, Physiology Technicians, Psychologists, Radiation Therapists, Medical Physicists, MRI Technicians and

Ultrasonography. This subsidy is based on a historic CTA funding model taking into account supervision and training times and providing an hourly rate for the supervisor and the trainee.

- Health workforce also contracts with the Pharmaceutical Council of New Zealand Incorporated to support 180 pharmacy internships.

Midwifery ($5.3m, 2.5%)

Health Workforce contracts with the New Zealand College of Midwives, and the Midwifery and Maternity Providers Organisation. These contracts have four main areas of focus:

- First Year of Practice – compulsory transition support programme for all graduates to support them in their first year of practice. The Programme is a fully funded national programme and provides a framework of support for newly graduated midwives in their first year of practice. This is delivered by the College of Midwives.
- Postgraduate training and complex care training programme – for midwives to demonstrate ongoing professional development and education and maintain competence to practice.
- Midwifery Standards Review. Midwifery Standards Review (MSR). The MSR is a quality assurance process developed by the New Zealand College of Midwives which supports competence of registered midwives. Through MSRs, midwives work with reviewers to reflect on their midwifery practice and identify a professional development plan. The Health Workforce contract provides for the costs of recruiting and training midwives as reviewers.
- Rural Midwifery Recruitment and Retention Services, aiming to increase the rural midwifery workforce to a level sufficient to meet demand, and improve retention. It provides orientation, financial support for relocation, a contribution to establishing a shared practice, as well as providing locum cover and mentoring for rural midwives.

Mental Health and Addiction (36.5m, 17.1%)

Health Workforce has contracts with six organisations to deliver workforce development and leadership for the mental health and addiction workforce. Mental Health funding increased by $13.9m in Budget 2019.

The majority of the original funding is with four ‘workforce centres’ delivering a range of workforce development services across the country. These services vary, but typically include workforce leadership, training, career pathways, and pastoral support. Some centres have moved to annual work plans to provide greater flexibility. Each centre has a specific area of focus, including:

- Te Pou, is the national centre for workforce development for the mental health, addiction and disability sectors in New Zealand.
- Pacific Inc (Le Va), workforce centre focused on the pacific mental health and addictions workforce.
- Te Rau Ora, workforce centre focused on Māori mental health workforce.
- Auckland UniServices Ltd (Werry Workforce Wharaurau), workforce centre focused on infant, child and adolescent mental health services.

Health Workforce provides additional support for a range of training including:

- grants for support-workers undertaking relevant NZQA level 4, 5, and 6 qualifications at Careerforce. This has typically been underspent, but anticipates significant growth in uptake in 2020 and 2021 due to the recent pay equity settlements.
- financial support for Māori mental health and addiction workers to undertake tertiary training at Massey University.
- funding for delivery of didactic reaching as required as part of the Advanced Psychiatry Registrar Training Programme.
- a mental health coordinator for the South Island.

Disability Support ($3m, 1.4%)

Funding to support development of the disability support workforce. This funding is mainly through a contract with Te Pou Limited. Te Pou provides general workforce development and workforce leadership for the disability support services workforce, with an aim to 'transform' the workforce recognising the objectives of the United Nations Convention on the Rights of Persons with Disabilities.

Te Pou provides two main services:

- Grant funding and administration, for disability support workers, disabled people and their carers, family and whānau to help access training and development opportunities.
- Workforce leadership, development, and innovation, including strengthening the transformation of the workforce, strengthening rights and values best practice, supporting career promotion and planning. This includes working with the Ministry of Health to help implement the Disability Workforce Action Plan, and monitor and report on the progress and delivery of the plan.

Te Pou delivers an annual workplan setting out which activities will be undertaken each year to deliver on the contracted services.

A small amount of funding is contracted to another provider to provide a subsidy for the training and supervision of medical registrars in the rehabilitation medicine training programme.

Māori Support ($2.75m, 1.3%)

Health Workforce operates two funds aimed at supporting Māori to undertake and succeed at training within the health system.

- The Māori Support Fund is complementary to other training programmes, and aims to enhance the likelihood of the Māori workforce successfully completing health-related training programmes by providing Māori support that is culturally competent and technically relevant to the training programme.

  The fund is largely focused on supporting Māori trainees to succeed in other training, through access to mentoring, cultural supervision, and cultural development activities that enhance the personal, cultural and professional self.

Māori Support is funded through the 20 DHBs and some NGOs, providing cultural support for Māori participating in other core training programmes, for example the Nurse Entry to Practice programme.

- Hauora Māori Training Fund, across 20 DHBs, which provides support for Māori kaiāwhina to develop formal competencies and potential to move into other health sector roles, as well as funding to DHBs to provide flexibility and responsiveness to training and development needs of their local and regional Māori non-regulated workforce.

Pasifika Support ($0.15m, 0.1%)

The Pacific People's Support Fund is complementary to other training programmes and aims to enhance the likelihood of the Pasifika workforce successfully completing Ministry of Health funded training programmes by providing Pasifika support that is culturally competent and technically relevant to the training programme.

The fund is largely focused on supporting Pasifika trainees to succeed in other training, through access to mentoring, cultural supervision, and cultural development activities that enhance the personal, cultural and professional self. Funding includes a focus on cultural support, and access to course related costs. It is funded through contracts with the 20 DHBs.

Voluntary Bonding Scheme ($6.92m, 3.2%)

The Voluntary Bonding Scheme (VBS) is an initiative established in 2009 to encourage newly qualified health professionals to work in the communities and specialties that need them most, and to retain essential health professionals in New Zealand. Each year the Ministry opens a 6-week registration of interest period to allow new graduates (and GP trainees) to register an intent to work in specified eligible hard-to-staff professions, specialties and communities.

The agreement is directly between the Ministry of Health and the applicant – the employer is not involved. Those accepted onto the Scheme receive payments to help repay their student loan or as top-up income.

Defined areas are typically at the DHB catchment level, but in some cases exclude urban or metropolitan areas. Specialties include aged care and mental health nurses, GPs, and sonographers. The eligible areas and specialties within the Scheme are reviewed annually via a mix of government priorities, stakeholder submissions and workforce analytics, although there is not currently a set process or criteria.

Successful applicants must work in the specified profession or area for a minimum of three years to receive the bonding payments, and may receive payments for up to five years.

Table: Voluntary Bonding Scheme Intake

Workforce / Profession	2018	2019	2020
New Graduate Doctors	36	27	0
General Practice Trainees	24	35	30
Nurses	232	216	265

Workforce / Profession	2018	2019	2020
Midwives	58	67	70
Allied Health (Sonographers)	7	9	6
Dentists	3	3	4

Other investments ($4.07m, 1.9%)

Health workforce makes a range of other investments including contracts with:

- Workforce Innovations.
- Training for the Health Practitioners Disciplinary Tribunal.
- Regional Workforce Directors, to demonstrate leadership and commitment to supporting the development of the region's health workforce. The directors are funded by Health Workforce and collaborate between Health Workforce, regional shared services agencies, DHBs, the broader health sector, education providers, and professional associations.
- Other contracts not elsewhere classified with a range of providers largely focused on data purchase and other activities that enable Health Workforce to undertake its workforce stewardship role.

Wider investments across the workforce pipeline

There is a modest amount of other funding from the wider Ministry of Health targeting specific objectives within the Health Workforce, for example to promote Māori or Pasifika workforce participation or progression. This will be explored in Phase 2 of the project.

Investment mechanisms

Based on this review of funding, it appears that Health Workforce draws on two main investment mechanisms - subsidising transition for the core workforce in post-graduate clinical settings, and investing in cross-cutting priorities.

Supporting transition of recent graduates into the workforce. This includes:

- support meeting occupational regulation requirements (such as registration for junior doctors) that are not covered by the education system. It is largely achieved through subsidising the supervision costs for the medical and allied health workforce
- support for midwives and nurses to transition into the workforce in their first year (unrelated to occupational regulation), as well as maintain ongoing competency levels.

This funding has limited flexibility. It is largely demand driven – current policy means that funding is guaranteed for all government-funded graduates, for example Medical PGY1 funding is guaranteed for all New Zealand government-funded medical graduates; similarly, funding is guaranteed for all New Zealand midwifery graduates for the Midwifery First year of Practice programme.

Cross-cutting investments in strategic priorities to meet identified health workforce priorities for the government, including:

- targeted funding to support workforce development for the mental health and addictions workforce, and disability support workforce. These workforces include both kaiāwhina and regulated professions, for example, support for nurses to undertake the Nurse Entry to Specialist Practice programme to increase the number of nurses trained to deal with mental health. Health Workforce also provides funding to support workforce leadership and planning
- support for greater participation by Māori and Pasifika, including financial support (through grants and scholarships) pastoral care, and mentoring to support greater achievement and progression
- greater access to health workforce in rural areas and regional areas, through the voluntary bonding scheme to encourage priority workforces to take positions in areas of higher need.[7]

This funding is likely to be more responsive to emerging health system priorities. Constraints within the Health Workforce funding mean that new initiatives largely need to be funded by seeking additional funding through Budget Bids.

Funding levels vary significantly

Core workforce funding is largely based on historical decisions and varies significantly. With the vast majority of funding allocated to subsidy-based transition support, historical cost models and pricing/fee schedules have a significant impact on where and how funding is spent.

The subsidy-based fee schedules vary significantly by workforce, as they are based on the relative costs of the different workforce. For example, the contribution to:

- Medical - training ranges from $15,495 per annum for support in achieving a diploma in Obstetrics and Gynaecology, to more than $67,000 per annum for a Palliative Care Hospice Rotation. The average contribution by profession is around $45,000 per training unit.
- Allied health - training is around $27,000 per training unit per annum, depending on profession.
- Nursing - receives a subsidy of $7,200 per Nurse Entry to Practice programme participant and $7,374 - $9,714 per PG Nursing participant (and $28,404 per participant on the nursing postgraduate prescribing practicum). Variations are largely based on whether the programme includes clinical mentoring.

The Ministry is aware that current subsidy levels for these contracts, especially medical and allied health, are unlikely to cover the true cost of providing supervision or training. For example, the subsidy for the Nurse Entry to Practice is based on nursing salary levels in 2006. This shortfall likely needs to be covered from elsewhere within constrained health budgets.

[7] Core workforce investment also includes targeted GP training placements in rural and regional areas, and rural midwife recruitment and retention support, and medical multidisciplinary immersion training.

How success is measured

Success measures are defined within the Vote Health appropriations. Measures are focused on participation rates (how many people are supported through training) and for some workforces, retention rates and achievement rates.

Table: Key performance indicators

Workforce category	
Medical	• Supporting an agreed number of trainees for general practitioners, vocationally registered specialists, and post graduate trainees • The retention rates of these workforces after two and five years
Nursing	• The number of participants in the Nurse Entry to Practice and the Nurse Entry to Specialty Practice programmes
Midwifery	• Number of trainees supported by the Ministry, and the percentage of all graduates who participate
Mental Health	• Number who achieve a mental health and addiction related qualification
Disability Support Workers	• Number working towards a disability related qualification
Voluntary Bonding Scheme	• Retention rate within the scheme, based on number of applications in the previous year who applied again in the current year
Hauora Māori Support	• Percentage pass rate
Māori and Pasifika support funds	• Percentage pass rate

Source: Vote Health Estimates, Ministry of Health contracted arrangements.

Health Workforce requires regular reporting from service providers to measure against this. Reporting requirements vary at both levels and intervals, for example, Medical generally report quarterly, whereas Nursing report on a month-month basis. Trainee numbers for key workforces are held within the Clinical Training Agency database including:

- Medical
- Nursing
- Allied Health
- Midwifery
- Hauora Māori Non-Regulated Workforce working towards a NZQA accredited qualification
- Where applicable, recipients of Māori and Pasifika support funds, reported as part of the other Health Workforce funded programmes reported through the CTA database.

While requirements will vary by contract, nursing contracts require the following details: APC No. Name, Ethnicity, Iwi, Employee, Clinical Service Area, Paper title, Qualification, Expected completion date. Most entries also include purchase unit number.

Some funds have been evaluated. For example:

- A 2015 evaluation of a short term NETP initiative for new graduate nurse employment in primary care in 2012/13. This evaluation found trainees in this scheme were more interested in a career in primary care as a result of the scheme and wanted to remain in primary care. Of the 45 practices involved, 78% were continuing to employ the new graduate nurses beyond the year funded by the scheme
- A 2017 evaluation of the Midwifery First Year of Practice programme to determine the efficacy of the programme, identified issues and challenges faced by participants and service users, identified opportunities for improvement and provided direction for the programme.

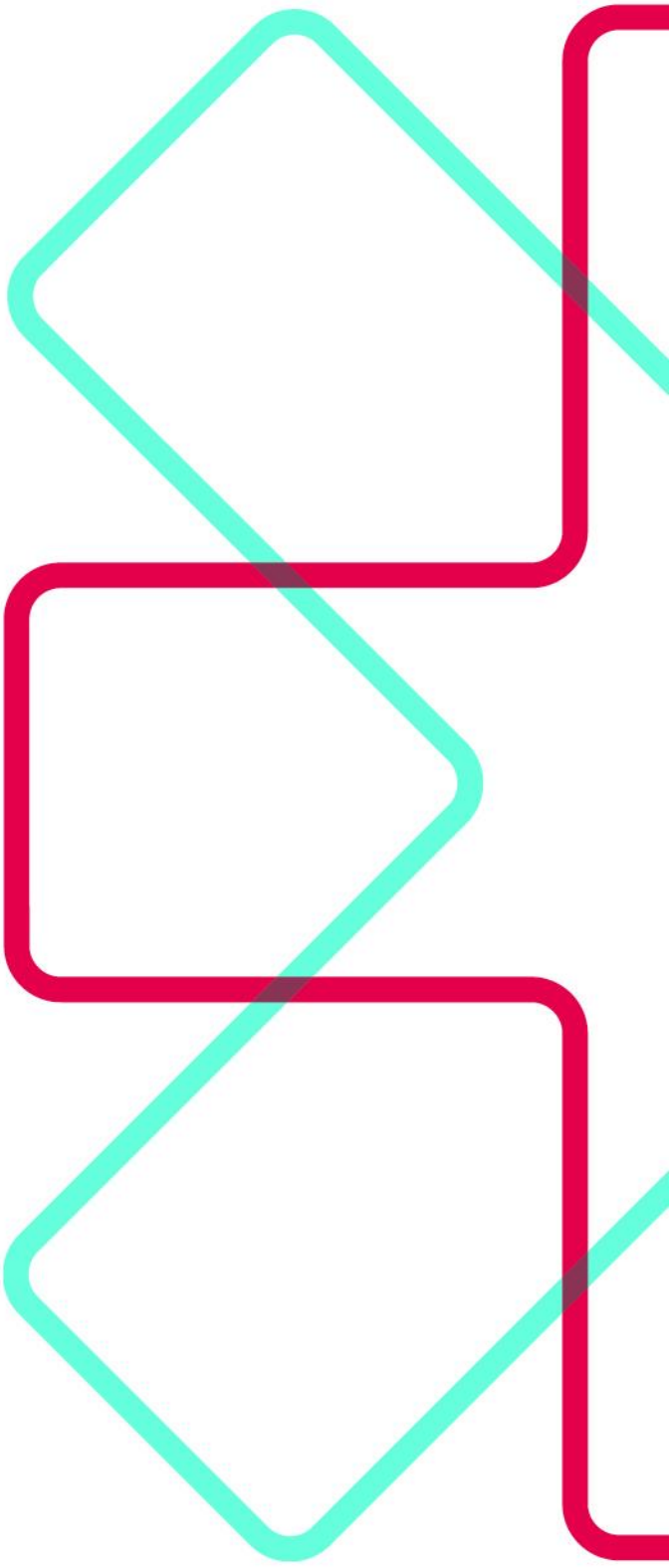
  While the evaluation found the programme to be successful across the four criteria evaluated, it is not clear how these connect to higher level objectives relating to retention and availability of the workforce.[8]

The Ministry has noted a desire to:

- Shift from reporting on the number of health professionals funded, to where they work and in which specialties, to align with government priorities and health workforce needs based modelling/projections
- Develop measurable outcomes that reflect this shift and include workforce and population health outcomes.

[8] Responsive to mentee needs (well supported mentees, skilled practice); - Builds confidence (confident practice); - Supports ability to adapt to multiple contexts; Supports positive attitudes and realistic expectations about midwifery practice.

NEXT STEPS



Phase 2 and 3 of the review

This document provides an initial overview of the health workforce system and how the Health Workforce Directorate within the Ministry of Health invests. It is intended to help establish a basis for further investigation of a future state where funding is utilised where it is needed most and makes the most impact.

There are a number of areas in the report that will require deeper investigation. This work will continue through engagement with stakeholders to better understand workforce demand and supply, segmentation of workforces, investment choices and overall outcomes sought.

The focus of the review now moves to extensive engagement with stakeholders. The outputs from this engagement will help to inform the development of a new funding model. Reflecting the views and thoughts of stakeholders will provide robustness around any recommendations and ensure accurate reflection of the health workforce.

Engagement will occur with internal and external stakeholders in late 2020 and early 2021 with a new model planned to be in place from mid-2021.

APPENDIX 1: ALLIED HEALTH

Below is a list of most of the professions generally regarded as allied health (including science and technical) professions. Some are regulated under the HPCA Act, as indicated with an asterisk.[9]

- Anaesthetic technicians*
- Audiologists
- Biomedical engineers and electronic technicians
- Cardiac sonographers*
- Chiropractors*
- Clinical dental technicians*
- Clinical perfusionists
- Clinical physiologists – dialysis (renal dialysis technicians)
- Clinical physiologists – respiratory
- Clinical physiologists and technicians – cardiac
- Clinical physiologists and technicians – sleep
- Counsellors
- Cytogeneticists
- Dental assistants
- Dental hygienists*
- Dental technicians*
- Dental therapists*
- Dietitians*
- Dispensing opticians*
- Diversional therapists
- Drug and addiction counsellors
- Exercise physiologists
- Family and marriage counsellors
- Gastroenterology scientists and technicians
- Genetic associates
- Hospital play specialists
- Magnetic resonance imaging technologists*
- Massage therapists
- Medical imaging (or radiation) technologists*
- Medical laboratory scientists*
- Medical laboratory technicians*
- Medical photographers
- Medical physicists
- Music therapists
- Neurophysiology scientists
- Neurophysiology technicians
- Nuclear medicine technologists*
- Occupational therapists*
- Optometrists*
- Orthoptists
- Orthotists and prosthetists
- Osteopaths*
- Paramedics
- Pharmacists*
- Pharmacy technicians

[9] Source: Ministry of Health, Health of the Health Workforce

- Physiotherapists*
- Podiatrists*
- Psychologists* (clinical, educational, child and family, counselling, health and neuropsychologists)
- Psychotherapists,*
- Radiation therapists*
- Rehabilitation counsellors
- Social workers
- Sonographers*
- Speech and language therapists
- Sterile service technicians
- Traditional Chinese medicine practitioners
- Vision and hearing technicians
- Visiting neurodevelopmental therapists

APPENDIX 2: KAIĀWHINA

This list comprises the non-regulated occupations regarded as part of the kaiāwhina workforce.[10]

- Child or youth residential care assistants
- Community health workers
- Community health workers – public health
- Disabilities services officers
- Diversional therapists
- Family support workers
- Health care assistants
- Health diagnostic and promotion professionals
- Health promotion officers
- Home and community-based support workers for disabled, older or injured people
- Hospital orderlies
- Kaiāwhina hauora (Māori health assistants)
- Navigators
- Nursing support workers
- Peer support workers
- Personal care assistants
- Public health workers
- Rehabilitation assistants
- Residential care officers
- Sterile service technicians
- Support workers in residential facilities
- Therapy assistants
- Traditional Māori health practitioners
- Vision and hearing technicians
- Whānau Ora workers

[10] Source: Ministry of Health, Health of the Health Workforce

APPENDIX 3: VOLUNTARY BONDING SCHEME ELIGIBILITY 2020

2020 Voluntary Bonding Scheme Intake Health Professions, Hard-to-staff Communities and Specialties

Postgraduate General Practice Trainees (PGY3-6), who commence(d) GPEP1, 2, or 3 in December 2019:

- Bay of Plenty DHB (excluding Tauranga and Whakatane urban)
- Canterbury DHB (excluding, Christchurch other than Banks Peninsula)
- Capital & Coast DHB (excluding Wellington and Porirua)
- Hawke's Bay DHB
- Lakes DHB
- Midcentral DHB
- Nelson Marlborough DHB (excluding Nelson/Richmond)
- Northland DHB
- South Canterbury DHB
- Southern DHB (excluding Dunedin, Mosgiel and Invercargill)
- Tairawhiti DHB
- Taranaki DHB
- Waikato DHB (excluding Hamilton)
- Wairarapa DHB
- West Coast DHB
- Whanganui DHB

Registered Nurses (2020 Intake (2019 graduates))

Specialties:

- Aged Care (aged residential care and older persons' health services)
- Mental Health (hospital and community, including addiction services)

- District Nursing
- Well Child/Tamariki Ora
- Primary/Practice Nursing within:
- Māori or Pacific Providers
- the Auckland DHB region
- the Counties Manukau DHB region
- the Waitemata DHB region
- the Taranaki DHB region

OR

Communities:

- South Canterbury DHB
- Wairoa District
- West Coast DHB

Enrolled Nurses (2020 Intake (2019 graduates))

Specialties:

- Aged Care (aged residential care and older persons' health services)
- Mental Health (hospital and community, including addiction services)

Midwives – DHB Employed (2020 Intake (2019 graduates))

- Auckland DHB
- Bay of Plenty DHB
- Canterbury DHB
- Capital & Coast DHB
- Counties Manukau DHB
- Hutt Valley DHB
- Lakes DHB
- MidCentral DHB
- Northland DHB
- Waikato DHB
- Waitemata DHB

Midwives – Lead Maternity Carers (2020 Intake (2019 graduates))

- Auckland DHB
- Bay of Plenty DHB
- Counties Manukau DHB
- Lakes DHB
- MidCentral DHB
- Waikato DHB
- Waitemata DHB

Sonographers (2020 Intake (2019 graduates))

- Publicly funded health facilities

Dentists (2020 Intake (2019 graduates))

Any of the eight Māori oral health providers listed below:

- Te Hiku Hauora – Kaitaia
- Ngāti Hine Health Trust – Kawakawa
- Raukura Hauora o Tainui – Hamilton
- Te Manu Toroa – Tauranga
- Tipu Ora – Rotorua
- Ngati Porou Hauora – Te Puia Springs
- Te Taiwhenua o Heretaunga – Hastings
- Ora Toa PHO – Porirua

OR

practices located in rural or remote areas (to be assessed on a case by case basis prior to your confirmation on the Scheme).