



# Workforce Needs Assessment for MidCentral District

**16 September 2003**

# Table of Contents

<b>1.</b>	<b>Foreword</b> .....	<b>1</b>
<b>2.</b>	<b>Executive Summary</b> .....	<b>2</b>
	2.1 Primary Care.....	2
	2.2 Primary Health Organisations .....	4
	2.3 Interface between Primary and Secondary Care.....	5
	2.4 Oral Health .....	6
	2.5 Training.....	6
	2.6 Future of MidCentral District’s Workforce .....	7
<b>3.</b>	<b>Purpose And Objectives Of Evaluation</b> .....	<b>8</b>
<b>4.</b>	<b>Methodology</b> .....	<b>10</b>
	4.1 Philosophy of Approach .....	10
	4.2 Evaluation Tools.....	11
	4.3 Analysis and Presentation of Results .....	12
<b>5.</b>	<b>Findings</b> .....	<b>13</b>
	5.1 Workforce Statistics .....	13
	5.2 Qualitative Results .....	16
<b>6.</b>	<b>Evaluator’s Comments</b> .....	<b>45</b>
	Bibliography .....	47
	Appendix A: List of Evaluative and Investigative Questions Used in the Interviews.....	49
	Appendix B: List of Interviewees .....	52



# 1. FOREWORD

MidCentral District Health Board's vision is that

*“the people of our district enjoy the best possible health and independence.”*

A number of goals were determined to achieve this vision; one of these is for MidCentral to have “A collaborative, skilled workforce.” In its District Annual Plan 2002/03, the Board identified the assessment of workforce needs in the district as a key planning and funding initiative. The assessment was to include a stocktake of the existing health workforce in the district, and identification of gaps against the current and future trends in health and disability service demand, as well as changes in methods of service provision (eg. impact of new technologies and increased emphasis on preventative and primary health care services).

Technical Advisory Services (TAS), a shared support agency for the six District Health Boards in Central Region, was asked to undertake this assessment on behalf of MidCentral's Funding Division. An experienced evaluator was contracted by TAS to complete an extensive range of key informant interviews in MidCentral's district and provide qualitative analysis of the information obtained through this process. Key findings of this qualitative information gathering exercise are presented in this report.

The key concept underpinning the project was the definition of ‘workforce’. For the purposes of the project we have defined health workforce as number and skillmix of health providers available within the district. Traditionally, this includes a range of health professionals, such as general practitioners, medical specialists, nurses, midwives, pharmacists, dentists, laboratory technicians, radiographers, physiotherapists and many others.

The Funding Division's focus was essentially on providers in the primary health care sector, although interviews were conducted with secondary care providers in MidCentral Health. Providers of disability support services were excluded from this review as the Ministry of Health did not devolve to District Health Boards the responsibility for these services until 1 October 2003.

A local workforce plan based on the findings of this needs assessment has been commissioned.

## **2. EXECUTIVE SUMMARY**

This report draws together the views of a selection of primary healthcare providers based in MidCentral District Health Board (MDHB) area with respect to workforce needs in the district. It also reflects the views of a range of group managers at MDHB on the interface between primary and secondary healthcare provision.

The evaluation design was based on triangulated evaluation methodology. This methodology ensures validity and reliability by bringing together different sources of evidence to enable conclusions to be drawn about the workforce development needs in the MidCentral DHB area. We have also attempted to undertake quantitative analysis of available workforce information.

Unfortunately, the workforce statistics for most professional groups proved to be incomplete or out of date. Therefore, the report is based mainly on the qualitative information obtained through the process of structured interviews with a sample of DHB staff, primary care providers, clinicians and managers.

### **2.1 Primary Care**

There are some national shortages of primary healthcare providers that impinge on MDHB as on other DHBs (District Health Boards). These shortages centre around General Practitioners (GPs) and Practice Nurses. There are insufficient numbers of trained doctors becoming GPs, and fewer still choosing to work in rural practices. This in turn is creating a high workload for GPs who are absorbing patients from rural practices where GPs have not been replaced. Most responses from the interview sample of GPs centred on the difficulties of establishing an adequate healthcare skills base in rural areas.

Of particular concern is the low morale mentioned by almost all GPs interviewed. In addition to coping with high workloads, many GPs feel they do not have the specialised training to deal with the incipient mental health problems their patients bring to them. There is clearly a need for contract funded Counsellors and Social Workers to support GPs in rural practices. Early intervention from Counsellors could prevent the downstream effect of large numbers of patients who end up being referred to Mental Health Services.

The training of Nurse Practitioners is seen as a possible solution to the problem of insufficient GPs, but there are issues to be resolved with release time for Practice Nurses to complete the training. What is intended as another solution to

the shortage of GPs in rural areas is posed by a different model of team practice that involves a large number of staff and a very wide skills base, with doctors, nurses, locums, physiotherapists, radiographers and a Family Planning Nurse. This commercial approach to a multi-skilled practice can provide GP services in rural areas using a roster of GPs based in Palmerston North. Although this model gathers a wide skills base together to respond to the needs of a patient, superficially in much the same way a PHO is designed to do, it lacks the continuity of care and the attendant synthesis of trust that exists between a traditional family GP and their patients. It also requires a great many protocols to ensure quality control of patient care.

The success of Maori kaupapa based healthcare models and the district Independent Nurses Practice referred to in this report are premised on building a relationship of trust with the patient and being able to function as confidante as well as medical practitioner with an established sense of community. The holistic model of healthcare underpinning the philosophy of PHOs is premised on knowing the physical, mental and emotional health of individuals and thus being able to work towards wellness rather than constantly reacting to illness. Thus care must be taken to ensure that models of team practice capture and retain the intent of PHOs.

As with GPs, there are insufficient Practice Nurses available in the district. The impact of this is high workloads in practices, particularly rural practices, and a lack of nurses to support Maori Health Providers, Mental Health Providers and specialist clinic services. The level of support for Practice Nurses is set by the culture of the GP and varies accordingly.

A shortage of Counsellors in the district workforce is significant and is reiterated by a large number of primary healthcare providers: GPs, Practice Nurses, Maori Health Providers and Mental Health Primary Care/Community Providers. The providers in the interview sample see the enormous benefits of using Counsellors in an early intervention model for patients with potentially serious long term mental health problems. The role of Maori Community Workers is also a strength in the promotion of wellness and as an early intervention technique.

Other skills shortages that impact on primary healthcare are:

- Podiatrists (severe shortage)
- Key workers and mental health liaison nurses
- Maori GPs and nurses
- Maori Community workers

- Diabetes specialist nurses
- Wound care specialist nurses
- Occupational therapists
- Speech therapists
- Dieticians.

## 2.2 Primary Health Organisations

A number of workforce, information and communication issues need to be addressed with respect to the successful implementation of PHOs. The Practice Nurses interviewed see that healthcare providers needed to move beyond individual professional protection of information for information technology to work for the benefit of patients. They see that education of the providers is the issue to be addressed for information technology to be truly useful. They believe that communication between primary and secondary healthcare is still of a poor standard and that medical documentation (e.g. referral letters) are not inclusive of information from all primary health carers involved in the care of a patient. Pharmacists and physiotherapists are keen to support information sharing with levels of access to protect confidentiality, and GPs cautiously so. If information is not shared, the lack of liaison with respect to patient information will continue. It would be preferable to have an individual wellness plan follow a patient through a primary-secondary-primary healthcare cycle.

There are a number of providers who feel strongly that they should be involved in the establishment of PHOs. Pharmacists, Dentists and Dental Therapists all make a valuable contribution to healthcare and understanding the needs of individual patients in the community. The paradigm shift to PHOs is dependent on pooling valuable skills and can only be enriched by a wider inclusion of providers.

Cultural awareness and the sensitivity around dignity of individuals is of paramount importance in the new PHOs. Although many healthcare providers in the district consider their existing services to be culturally appropriate, there are clearly some services that need to discover ways of making Maori feel more comfortable. This is also a workforce issue to be considered. MDHB should broker liaison between GPs and Dentists and Maori Health Providers to explore ways of making waiting rooms and administration procedures more culturally sensitive. Funding more Maori Community Workers to encourage use of existing medical and dental services among Maori is a solution which is easily implemented, while the training of more Maori GPs and nurses is a longer term goal.

## 2.3 Interface between Primary and Secondary Care

Primary healthcare providers felt that the issue of accessibility was dominant in secondary care, and that while public expectation was that most medical conditions will receive a prompt response, the providers' perception is that only acute cases are seen. Transport was mentioned by almost all providers as a source of huge frustration and concern in rural areas, leading to patients from rural areas being disadvantaged in terms of ready access to secondary healthcare provision.

The view of MDHB group managers mainly reflected the concerns expressed by the primary healthcare providers. Workforce shortages were reported as follows:

- Shortage of psychiatrists, psychologists and nurses (particularly in rural areas) in Mental Health services. Concerns were expressed by both Mental Health Primary /Community Providers interviewed that the hospital crisis team appeared to be under pressure with the volume of work
- Need to build capacity for nursing; the skill mix for nursing is impoverished and there is no workforce infrastructure in primary health care (no leadership, education framework, career pathway, no thinking time and no mentoring)
- There are no periodontists or endodontists in Palmerston North, and there is an increased workload on secondary care because of suspicion from dentists about government contracts that provide little reward for efforts. More money in the system would lower the threshold of restrictions on need levels, and early intervention would be cost saving
- Podiatrist based at Palmerston North Hospital has an overload of work; peripheral vascular disease and diabetes are the priority
- The renal unit is overwhelmed with patients suffering late complications of diabetes
- A Social Worker, possibly a Counsellor, is needed as part of the diabetes team, for cognitive behaviour therapy, to work with adolescent patients and their families to effect lifestyle changes
- Dieticians are insufficiently funded for enough hours to support the diabetes team.

MDHB is looking at developing a better work environment for secondary healthcare staff, working with staff, unions and delegates to identify areas to

improve the work environment and achieve a healthy work and life balance for all staff. Attracting staff to provincial, and especially rural, areas is a problem. Branding Palmerston North and positive marketing of Manawatu are recruitment strategies. MDHB is also looking at recruiting from overseas and sharing some positions between different DHBs.

A set of core values is being developed to create a more supportive work environment and thus help improve retention rates. These values will flow through to job descriptions. The way in which different groups work together will be considered for each area.

## **2.4 Oral Health**

There are some difficulties surrounding MidCentral DHB contracting for dental services in the district that are contributing to dentists being unwilling to take on MDHB contracts. On a DHB planning and funding level, there are concerns over the perceived lack of communication with dentists about accreditation of their Practice Quality Systems. Delays in approving accreditation have resulted in dentists being unable to claim increased per capita funding on contracts for 13-18 year old young people. The Special Dental Benefits contract for young children is considered to be underfunded, as is the contract for patients who are holders of Community Service Cards.

Whereas there are sufficient dentists for private practice needs in the district, the DHB should consider ways of increasing the uptake of service contracts among the dentists, making these services more accessible to target groups of patients. There is a looming shortage of dental therapists, with no career pathway. Specialist dental services for the district are considered to be good in Palmerston North, but not in Levin.

Dentists referring patients to secondary dental care at the Palmerston North Hospital, under the public system, expressed concern about waiting times for orthodontic patients. Some patients needing endodontic and orthodontic treatment are referred, instead, to Wellington. There is concern about children who need to be seen urgently, and a concern about a perceived lack of procedures for prioritising patient need at the hospital.

## **2.5 Training**

Training opportunities are generally considered to be available but not necessarily accessible to primary healthcare providers. Thought should be given

to the choice of time and venue for training sessions, to accommodate rural practitioners. A number of providers believe that healthcare providers with different skills bases should train together, for example GPs, nurses, Maori Healthcare Providers and Mental Healthcare Providers. Encouraging networking through training is a positive way of developing workforce capability through shared understandings. Maori Healthcare Providers would like to be considered for accreditation as trainers, using a hapu-based model.

## **2.6 Future of MidCentral District's Workforce**

The Health Workforce Advisory Committee, which was established in 2001 by the Minister of Health, points us to some of the new and emerging approaches to workforce planning and development, such as the 'models of care' approach. That approach considers the total workforce skill mix available for the delivery of quality health care and has a person-centred and patient-involved focus. It no longer sees professions in isolation but gives consideration to all workforce groups. It is oriented towards competencies and continuing skill and knowledge development, and requires responsiveness on the part of the practitioner to the person needing health services.

It appears to us that this recommended approach to workforce development fits very well with some of the key intentions of MidCentral DHB's draft Primary Health Care Strategy which seems to place great emphasis on multi-disciplinary primary health care teams that are person-centred and able to provide disease state management and coordinated care of people in the community. To realise this vision, MidCentral DHB, in partnership with health care providers and other stakeholders, will need to determine and then systematically develop the set of skills and competencies that will be required by district's health workforce in order to participate in the future model of health service delivery.

The problem of health workforce planning and development in the MidCentral district results from a complex interplay of many significant factors such as: quality standards and health care legislation, broad environmental trends (in population, economy, technology, labour markets), education and training of health professionals, consumer expectations, changes in service delivery, and issues with recruitment, retention and workplace environment. Many of these factors are outside of DHB's sphere of influence or control and none of them can be solved by DHB alone. It is only through partnership and active collaboration with other responsible national, regional and local agencies, professional groups, provider organisations, educational institutions and communities of interest that MidCentral DHB can plan and develop the health workforce in the district.

### **3. PURPOSE AND OBJECTIVES OF EVALUATION**

The purpose of the evaluation was to determine district workforce needs and increase the understanding of current capacity and skill gaps as well as projected future needs.

The main objective of the evaluation was to produce a report that would be indicative of the extent to which primary healthcare providers and relevant DHB staff perceive that the available health workforce meets community need. The report was also to consider the interface of primary and secondary healthcare in the district.

Potential benefits to MidCentral DHB of increased understanding of the workforce development needs were identified as follows:

- Provide input into MidCentral DHB's strategic and operational plans, such as the Primary Health Care Strategy for MidCentral District
- Have realistic expectations of health workforce availability when planning for new or additional service provision
- Provide an information basis from which MidCentral DHB can build a workforce development action plan in partnership with other responsible national, regional and local agencies.

The evaluation aimed to:

- Be pertinent to the context
- Take account of best practice in determining community health needs as identified by the Health Workforce Advisory Committee
- Take cognisance of current issues in health workforce provision as identified by the Health Workforce Advisory Committee
- Ascertain local community health needs from relevant documentation, MidCentral DHB staff and providers of health services in the district

- Ascertain present and future national workforce availability from professional organisations, relevant educational institutions, and employment agencies.

## 4. METHODOLOGY

### 4.1 Philosophy of Approach

The Evaluation Design is based on triangulated evaluation methodology. This methodology ensures validity and reliability by bringing together different sources of evidence to enable conclusions to be drawn about the workforce development needs of MidCentral DHB.

The following stages make up this process of evaluation:

- Initial Scoping
- Fieldwork Investigation
- Final Synthesis
- Reporting.

These stages are reflected in different aspects of the Evaluation Design:

- **Evaluation Scope:** Initial scoping occurs through the gathering of relevant background information from interviews and documentation.
- **Evaluative Questions:** These questions are formulated from the Evaluation Scope to focus the findings on determining the workforce development needs of MidCentral DHB. Refer Appendix A.
- **Investigative Questions:** These are more detailed questions that help to explore the big Evaluative Questions. They cover a range of information indicated by each Evaluative Question. Answers to these are sought during the fieldwork investigation and are corroborated by documentation. Refer Appendix A.
- **Evaluation Tools:** These are the means by which the Investigative and in turn the Evaluative Questions are answered. They can consist of pro forma to process information collected from documents, or pro forma to be used in interviews, questionnaires and observations.

- **Analysis of Data:** The information gathered during the fieldwork investigation is used to answer the Investigative and Evaluative Questions, and to verify key findings in a final synthesis.
- **Reported Key Findings and Conclusions:** Key findings are prioritised and conclusions drawn from the final synthesis.
- **Gap Analysis and Recommendations:** A gap analysis looks at those aspects of the present workforce provision that require further development to meet the future health needs of the community. Recommendations for workforce development are made on the basis of the gap analysis.

## 4.2 Evaluation Tools

### 4.2.1 Review of Documentation

The purpose of the Evaluation Scope is to determine the breadth and depth of the evaluation by analysing initial information. Documentation provided in-depth information on the background and issues for framing future directions for national and specifically MidCentral district health workforce. Documentation read for the purposes of the initial scope included:

- The New Zealand Health Workforce: A Stocktake of Issues and Capacity 2001; Health and Workforce Advisory Committee; April 2002
- The New Zealand Health Workforce: Framing Future Directions Discussion Document; Health and Workforce Advisory Committee; October 2002
- District Annual Plan 2002/2003: MidCentral District Health Board; December 2002
- District Annual Report 2002, MidCentral District Health Board
- District Health Board jobs for Nurses in New Zealand  
<http://www.nursy.com/Districthealthtxtjobs.htm>
- The Medical Council of New Zealand. Enable New Zealand. The New Zealand Medical Association. MidCentral DHB.  
<http://www.access.org.nz/links.htm>

- New Zealand Government and Agencies. Alcohol Advisory Council, New Zealand. Non-Government Health and Science Sites.  
<http://www.hrc.govt.nz/sites.htm>
- MidCentral DHB, <http://www.midcentral.co.nz>
- MOH: Nurse Practitioners in New Zealand  
<http://www.moh.govt.nz/moh.nsf>
- MidCentral District Health Board General Information regional basis, covering other DHB districts.  
<http://www.midcentral.co.nz/MDHB/MDHB-Info.htm>
- District Health Board vacancies in New Zealand  
<http://www.geocities.com/hotsprings/2271/Districthealthtxtjobs.htm>

#### **4.2.2 Fieldwork Investigation**

Interviews were conducted with:

- Staff from MidCentral DHB
- Providers of health services in the district
- Professional organisations.

A full list of interviewees is provided in Appendix B.

### **4.3 Analysis and Presentation of Results**

The information gathered during the on-site investigation is used to answer the Investigative and Evaluative Questions, and to verify key findings in a final synthesis:

- Qualitative information is grouped for each answer by healthcare provide groups (and one professional organisation)
- Open coding is used to analyse at thematic level for each answer
- Key findings and patterns are determined from these analyses, and are descriptive.

## 5. FINDINGS

### 5.1 Workforce Statistics

The following information was obtained from the Medical Council of New Zealand based on their Medical Workforce Survey 2001.

**Table 1: GP workforce by DHB area of main work site**

DHB area	Number of GPs	FTEs for GPs at all work sites <sup>1</sup>	DHB locality population	FTEs for GPs per 100,000 population
Northland	113	129	144,354	89
Waitemata	292	289	431,112	67
Auckland	392	389	380,154	102
Counties-Manukau	239	245	376,332	65
Waikato	258	280	328,164	85
Bay of Plenty	130	138	179,439	77
Lakes	78	84	103,329	82
Tairāwhiti	31	37	44,115	84
Hawkes Bay	108	115	146,574	78
Taranaki	67	69	102,786	67
MidCentral	95	116	147,684	78
Whanganui	44	49	59,052	83
Wairarapa	33	37	38,577	95
Hutt Valley	94	98	131,790	74
Capital & Coast	248	250	257,025	97
Nelson-Marlborough	98	98	130,923	75
West Coast	17	21	34,446	60
Canterbury	394	389	413,007	94
Otago	156	167	171,312	97
South Canterbury	56	69	79,971	87
Southland	94	95	119,526	80
<b>Total</b>	<b>3037</b>	<b>3163</b>	<b>3,819,672</b>	<b>83</b>

<sup>1</sup> The calculation of GP FTE includes all hours recorded in GP role at site 1, site 2 and site 3

Based on the above information, we can conclude that MidCentral DHB's GP numbers per head of population are in the middle of the range of all the DHBs in the country (minimum 60, maximum 102 FTEs per 100,000 population). In average, there are 1,273 people per GP full-time equivalent in the MidCentral DHB area. This is the same as Hawkes Bay and Bay of Plenty, and slightly better than Hutt Valley and Nelson-Marlborough (similar size DHBs).

However, further breakdown of MidCentral's area by Territorial Local Authority (TLA), reveals a more diverse picture as follows.

**Table 2: GP workforce in the MidCentral district by territorial local authority (TLA) of main work site**

TLA	Number of GPs	GP FTEs <sup>1</sup>	TLA population	FTEs per 100,000 population
Palmerston North City	57	69	73,125	94
Manawatu District	14	18	27,393	66
Tararua District	10	11	17,586	61
Horowhenua District	14	21	29,580	70

<sup>1</sup> The calculation of GP FTE includes all hours recoded in GP role at site 1, site 2 and site 3

Like other larger urban centres in New Zealand, Palmerston North has greater concentration of GPs (just over 1,000 people per GP FTE in average), while the surrounding rural areas have less GPs per capita (1,400 to 1,600 people per GP FTE in average). Palmerston North has more GPs per capita than Hamilton, Porirua, Lower Hutt, North Shore City or Manukau City, but less than Auckland City, Wellington, Christchurch, Dunedin or Nelson.

Dentists were the other professional group for which we have managed to obtain reliable workforce statistics. The Dental Council of New Zealand has provided us the results of their 2002 Workforce Analysis. Their analysis included an impressive range of detailed information, including age cohorts, ethnicity breakdowns, work type breakdowns and other useful planning information. Again, for the purposes of this report, we will focus on the geographical distribution only. This is presented in the following two tables.

**Table 3: Distribution of dentists by District Health Board (DHB) area**

DHB area	Number of dentists with APC 03 <sup>1</sup>	FTE dentists	Population-to-FTE dentist ratio	FTE per 100,000 population <sup>2</sup>
Northland	55	41.0	2,559.7	39.1
Waitemata	146	104.5	3,182.0	31.4
Auckland	366	284.8	1,036.9	96.4
Counties-Manukau	57	43.7	6,306.5	15.9
Waikato	105	85.3	2,821.8	35.4
Bay of Plenty	66	52.3	2,590.6	38.6
Lakes	34	29.1	2,463.2	40.6
Tairāwhiti	9	5.6	5,693.6	17.6
Hawkes Bay	44	38.1	2,853.1	35.0
Taranaki	32	27.3	2,880.2	34.7
MidCentral	53	43.5	2,755.6	36.3
Whanganui	15	12.6	3,824.0	26.2
Wairarapa	8	7.1	4,083.3	24.5
Hutt Valley	47	38.1	2,635.6	37.9
Capital & Coast	152	110.0	1,773.5	56.4
Nelson-Marlborough	55	42.6	2,253.7	44.4
West Coast	6	3.8	6,179.2	16.2
Canterbury	185	138.3	2,465.3	40.6
Otago	138	62.2	2,219.1	45.1
South Canterbury	23	16.5	2,526.5	39.6
Southland	41	36.7	2,195.4	45.5
<b>Total</b>	<b>1,637</b>	<b>1,223.0</b>	<b>2,361.9</b>	<b>42.3</b>

<sup>1</sup> Dentists who have a current Annual Practising Certificate, including dentists in dental practice, and those employed in Ministry of Health, Hospital and Health services, Government Departments, and other practice settings.

<sup>2</sup> This ratio was calculated using the population aged over 14 years.

Based on the above information, we can conclude that MidCentral DHB’s dentist numbers per head of population (aged over 14 years) are slightly below the New Zealand average but not too different from other similar size DHBs. Again, the breakdown by TLA reveals great discrepancy between potentially over-serviced urban area and under-serviced rural areas.

**Table 4: Distribution of dentists in the MidCentral district by territorial local authority (TLA)**

TLA	Number of dentists	FTE dentists	Population-to-FTE dentist ratio	FTEs per 100,000 population <sup>1</sup>
Palmerston North City	34	29.1	1,950.6	51.3
Manawatu District	4	4.0	5,190.0	19.3
Tararua District	4	3.7	3,590.3	27.9
Horowhenua District	11	6.7	3,441.5	29.1

<sup>1</sup> This ratio was calculated using the population aged over 14 years.

## 5.2 Qualitative Results

### EQ1 – Perceptions of Primary Care Providers:

To what extent do the current health providers for MidCentral DHB feel they meet, and can continue to meet, the needs of the community?

#### 1. WORKLOAD WITH RESPECT TO POPULATION RATIO IN PRACTICE

##### Responses from Dentists

Dentists in the MidCentral Health district are busy but have adequate time with each of their patients, whenever they have team practice support (a practice manager, receptionist, chairside assistants, a dental hygienist). Not all dentists have this level of support, however. They need to be realistic with the time they spend with each patient and need to work fast to make enough money from contracts held for adolescent and child health care. This is made easier when working with young children, since they do not have a history of past dental care. There are some significant issues arising from MidCentral DHB contract funding of dentists in the district. On a DHB administrative support level, there are concerns over the perceived lack of communication with dentists about

accreditation of their Practice Quality Systems. Delays in approving accreditation have resulted in dentists being unable to claim increased per capita funding on contracts for 13-18 year old young people.

While there appears to be sufficient dental care for young people in the 13-18 year old bracket in urban areas, the Special Dental Benefits contract for young children is considered to be underfunded, so some dentists refuse to see young children unless their parents are existing patients. The children who are not seen by dentists are usually referred to school dental nurses. One dentist expressed concern that Maori children often do not return after an initial visit to the dentist until they are adolescents with severe dental problems.

There are also funding issues with respect to patients who are holders of Community Service Cards. Funding for this group of patients is considered by dentists to be insufficient, resulting in a shortage of dentists who are willing to provide for this group. Whereas there are sufficient dentists for private practice needs in the district, the DHB should consider ways of making provision for this group of patients more attractive through the contracts system.

After hours cover is provided in Palmerston North by one practice providing seven day cover. This practice provides after hours cover for Palmerston North, Wanganui, Manawatu, Levin, Taihape and Lower Hawke's Bay through an internal roster of the two practice dentists. As many as 80 patients, mainly emergencies, have been seen in one day on public holidays.

All dentists in Otaki and Levin participate in rostered after hours cover for their areas and extend this to cover Foxton and Shannon. Locum cover is very difficult to find. When there are two or more dentists in a practice, they cover for one another internally. The seven day practice in Palmerston North has assistance from a nearby army dentist when necessary. Of the three dentists interviewed, two had access to peer support and professional review.

### **Responses from GPs**

All six GPs interviewed stated that their workload was high and that this impinged on the time and therefore the quality of service they were able to provide. It was acknowledged by all the GPs in the sample that the national average of 9.2 GPs per 10,000 population became more unrealistic the more rural the practice. In Feilding, where two practices have closed in the last 18 months, the GP ratio is 3.2 GPs per 10,000 population, and these GPs struggle when there are new patients to absorb. In Palmerston North the impact of an ageing population adds to the calls on GPs' time. One GP considered that there were enough GPs in the district for the present, but not for the future, and not to

promote wellness – work pressures produced a reactive workforce, too busy to set up proactive educative clinics for pressing community health issues such as asthma or diabetes. One urban GP follows a different model that offers healthcare without appointments and additional services such as X ray, physiotherapy and working with a Family Planning Nurse. These additional services, together with the accessibility of healthcare provision that requires neither registration nor appointments, are consistent with a predominantly commercial model of primary healthcare.

There are considerable problems in trying to find locums to cover for GPs. Three of the six GPs in the interview sample were unable to find locums and so had little time off; one of these GPs had holidays covered within the practice. One further GP has had a shared locum from overseas for the last few years, and yet another is part of an informal consortium of GPs who act as locums for one another. The sixth GP in the sample is part of a rural practice network contracted to the Ministry of Health to provide locum services that give a GP two weeks' holiday per year. All GPs in the sample stated that illness is difficult to cover.

The MDHB triage system for after hours cover was praised by all five of the GPs who participate in the scheme. One rural GP using the scheme also offers rural cover for the Hunterville, Marton, Bulls, Pahiatua area, whilst one urban GP using the scheme noted that most of the local after hours work went to The Doctors, which runs an accident and emergency service. The GP prefers patients to use The City Doctors because there is a guarantee that notes will be forwarded to the patient's own GP for continuity of record keeping. The one remaining GP not using the triage service finds after hours cover incredibly difficult. All GPs in the interview sample have access to peer review as well as informal support groups. The IPA provides peer review, and there is very good peer review in Feilding, where eight GPs meet every month.

### **Responses from Maori Health Providers**

All four Maori Health Providers interviewed expressed a need for more staff to meet community need. Gaining the trust of Maori clients was seen as taking time but leading to positive outcomes in addressing health issues and problems.

Locum cover for three Maori Health Providers came from whanau support. The fourth provider considered locum cover to be a huge issue for the clinic, with no replacement for GPs lost to retirement and burn out, and the prospect of raising charges to cover the resultant lack of availability of GPs. After hours cover comes from a variety of sources, including doctors, whanau support, and referral to the crisis team if necessary. All Maori Health Providers in the interview sample have good access to peer and individual supervision:

- Regular group supervision, and one to one supervision at times when external supervision is necessary from a Kaumatua
- Supervision outside the team is available, for example the Counsellor for A&D has supervision in Palmerston North
- Counsellors and Social Workers have peer review, though a contribution from individuals has to be paid
- Nurses offer one another peer review.

### **Responses from Mental Health Providers**

Key workers and Mental Health Liaison Nurses for the two mental health and community healthcare providers interviewed have extremely heavy caseloads. A need for earlier intervention for patients, and support workers for Psychiatric Nurses and Mental Health Liaison Nurses were two of the solutions offered by staff interviewed.

There is no pool of locums for cover for one of these providers; adjustments by colleagues to workloads are used to avert crisis management. After hours care is provided by the hospital crisis team, but concerns were expressed by both Mental Health Providers interviewed that the crisis team could not cope with the volume of work. Support for staff varied from one provider to the other; whereas one had trained supervisors that work with staff, the other referred to informal internal support.

### **Responses from Pharmacists**

Pharmacists acknowledged that part of their role was that of counselling individual customers about the medicines prescribed, but found that there was not sufficient time to offer that service to all patients. They prioritised use of their time by giving advice to customers who were having a change of medication, or by assisting older customers who were confused, were experiencing medication side effects, or needed tablets breaking into dosage portions. The sample of Pharmacists interviewed considered they often have a better overview of patients' progress than General Practitioners (GPs) because of the contact with patients returning for repeat prescriptions. They believe that this facet of their service can lead to early interventions for patients not taking their medication, not taking the correct amounts of medication, or experiencing side effects of medication. They expressed concern that this valuable aspect of a Pharmacist's service would be lost if patients were returning less frequently for prescriptions.

Two of the three Pharmacists interviewed have no locum assistance – one Pharmacist said there were no locums available, the other was concerned about the quality of any available locums. The third Pharmacist in the interview sample had locum assistance from another pharmacy but said that arrangements for locum coverage had to be made well in advance.

With respect to after hours cover, two out of the three Pharmacists manage some after hours coverage through taking part in a roster arrangement, whereas one Pharmacist offers late hours on selected days. All Pharmacists in the sample believe that customer expectation of receiving an after hours service reduces the appeal of the job. Informal collegial support is available for Pharmacists in larger pharmacies, though formal mentoring is not available.

### **Responses from Physiotherapists**

The two Physiotherapists interviewed referred to the need for group practices for viability, and noted that small practices were not surviving. Although there are no waiting lists, clients are not usually able to get an appointment on the day of contact. There are seasonal fluctuations in demand because of an increase in winter due to sports injuries.

There is no locum base for Physiotherapists, but they are able to cover for each other if there is a critical mass of staff in a practice. Similarly, after hours cover for emergencies, including cover for private hospitals, are provided through a rostering system. The Physiotherapists interviewed have a peer review arrangement with other clinics as well as an internal support system within larger clinics.

### **Responses from Practice Nurses**

Practice nurses have a heavy workload in rural areas. This is partly because additional services, for example taking laboratory samples, are provided for patients (unlike city practices). A more recent factor is the number of rural GP practices that are for sale but remain unsold, resulting in established rural practices having to absorb significant numbers of additional patients. Nurses in one practice are booked three days in advance and know of another practice with similar problems.

Independent Practice Nurses, who staff a rural practice run by a Trust, have enough time with each patient and feel well supported by the community.

All four Practice Nurses in the interview sample stated that locum cover need was absorbed within each practice. They did, however, acknowledge that there are

problems with locum cover for practices with only one Practice Nurse. The nurses interviewed were not part of an after hours service, although one rural nurse is a rostered ambulance officer.

Internal support was available for all four nurses within their practices, and peer support was available from the Independent Practitioners' Association (IPA) as well as the Association for Manawatu Practice Nurses. This external support was seen as invaluable for nurses working in small solo practices.

### **Responses from other providers**

An indicative sample of one Midwife, one Diabetes Trust Manager and one Palliative Care Hospice Manager showed little concern about staffing issues, though the Palliative Care Hospice Manager noted there were not enough Practice Nurses as compared to GPs. Midwives work in collectives and cover for one another for locum work, and Hospice staff are rostered to provide 24 hour care, though some concern was expressed that locum GPs are not always trained in palliative care.

The Diabetes Trust Manager expressed concern that there was a lack of specialist after hour services for patients on insulin who have blood sugar spikes or broken equipment, though the two biggest pharmacies in Palmerston North try to deal with these issues. All three indicative sample interviews showed good supervision support and practices in place.

## **2. TEAM PRACTICE SUPPORT**

### **Responses from Dentists**

The three dentists interviewed had teams that had enough team practice support (reception/administration and chairside support) but were aware that this was not the case for smaller practices where the chairside support person may also have to be the receptionist.

### **Responses from GPs**

All six GPs interviewed felt that they had good practice team support and that their practice cultures were dependent on doctors and nurses working together as a primary healthcare model. The IPA was seen by two GPs as pivotal to the support mechanisms in place for their practices. These support mechanisms ranged from providing nurses to support Practice Nurses on difficult issues to tools for policies, resources, and proactively about health issues. Support for GPs in terms of referrals and second opinions was perceived as lessening, the further

away a practice was from the radial support of Palmerston North Hospital. This was seen as resulting in a lack of equity for rural patients.

One GP operated a different model of team practice that involved a large number of staff and a very wide skills base, with 11 doctors, 12 nurses, four locums, four physiotherapists, two radiographers and one Family Planning Nurse. This practice required a lot of protocols to ensure quality control of patient care.

### **Responses from Maori Health Providers**

All four Maori Health Providers had strong team practice support, and modelled a supportive team culture, irrespective of team role. The role of Maori community workers and counsellors was seen as a strength in the promotion of wellness and as an early intervention technique. One Maori Primary Healthcare Provider had to use a health practitioner as administrative support because of minimal resources.

### **Responses from Community Based Mental Health Providers**

Both Mental Health Providers interviewed felt that they needed more team practice support and that they could provide this with more resources. One provider interpreted team practice support in a wide sense, inclusive of psychiatrists at Palmerston North Hospital as well as referring GPs, and felt there were inherent difficulties through lack of availability of psychiatrists, and a lack of specialist knowledge of GPs.

### **Responses from Pharmacists**

The three pharmacists interviewed are concerned about attracting new and sufficient staff to pharmacy work in the district. Localities overseas and larger cities in New Zealand are the destinations of choice of many newly-qualified New Zealand trained pharmacists. The degree of practice team support relates directly to the size of the pharmacy – in smaller pharmacies the stress of multi-tasking leads to concern about the possibility of making mistakes. Pharmacy to pharmacy support in the district is good and is not adversely affected by business competition.

### **Responses from Physiotherapists**

The two physiotherapists interviewed referred to the importance of having one or more physiotherapists in a practice, offering different specialist skills, for example elderly wellbeing, ergonomic workplace education, and work related to sports injuries. Increasingly Physiotherapists are concentrating on a holistic

wellness model, with team support from exercise and massage therapists and personal trainers.

### **Responses from Practice Nurses**

The three Practice Nurses interviewed had different experiences of team practice support. One saw that team support at her practice meant that nurses were taking on a lot of what was traditionally GP work, and that nurses were acting as patient advocates, encouraging patients to attend the Medical Centre. She felt that the team was committed to excellence by providing ongoing education for the team, realising that individual nurses had different levels of skills.

The second nurse also felt that team practice support at her practice meant that nurses were taking on a lot of what was traditionally GP work. She received encouragement from the GPs to become a Nurse Practitioner. This was a pragmatic teamwork response to a very busy practice with a very heavy workload. It was acknowledged that the level of support for Practice Nurses was set by the culture of the GP.

The third nurse in the interview sample worked in a different structure, as an Independent Practice Nurse, and this practice worked extremely well with diverse team support from two GPs once a week, physiotherapy support once a week, Plunket Nurse support fortnightly, counselling support on a needs basis, and additional CIF funding for counselling for children. There was an emphasis on wellness and prevention of illness in this practice, which functions with an established sense of community and a view of holistic health, so that services for budget counselling are offered by the practice employer (a Trust) in addition to a Food bank.

### **Responses from other providers**

The indicative sample of one Midwife, one Diabetes Trust Manager and one Palliative Care Hospice Manager reported good practice team support.

## **3. SKILL MIX OF HEALTH PROVIDERS IN THE DISTRICT**

### **Responses from Dentists**

Views on the skill mix of health providers in the district vary according to area. During interviews, references were made to an international shortage of dentists that is impinging on New Zealand. Although enough dentists are trained in New Zealand itself, many are lured by overseas markets at the end of their training. There is also a perception that there is a national shortage of dental nurses in

primary schools. This perception from dentists in primary health care provision was borne out by the Clinical Director Dental Services MDHB. Specialist dental services for the district are considered to be good in Palmerston North, but not in Levin. Having had an orthodontist in Levin for 10 years, this service was lost at the beginning of 2003.

Dentists referring patients to secondary dental care at the Palmerston North Hospital, under the public system, expressed concern about waiting times for orthodontic patients. Some patients needing enzootic and orthodontic treatment are referred, instead, to Wellington. There is concern about children who need to be seen urgently, and a concern about a perceived lack of procedures for prioritising patient need at the hospital. When interviewed, the Clinical Director Dental MDHB stated that the waiting times for oral surgery were between nine and twelve months, and that there were no peritonitis's or endodontists in Palmerston North. He believed that more money in the system would lower the threshold of restrictions on need levels, and acknowledged that dentists often avoid government contracts because they feel there is little reward for effort, thus increasing the workload on secondary dental care. The Clinical Director Dental MDHB also pointed out that there was an imminent workforce shortfall of dental therapists, who are an ageing workforce with low recruitment rates to training programmes.

Transport for patients in the public health system, who require oral surgery at the hospital, is an issue when these patients live outside Palmerston North. Patients often do not keep appointments because of a lack of transport.

### **Responses from GPs**

Most responses from the interview sample of GPs centred on the difficulties of establishing an adequate healthcare skills base in rural areas. Although one GP stated that there was a perfectly adequate skill mix (based on GPs and Practice Nurses being the backbone of primary healthcare) that simply needs maintaining, four other GPs referred to specific skills base shortages in rural areas.

There is clearly a need for contract funded Counsellors and Social Workers to support GPs in rural practices. One GP estimated that there is a need for half a dozen Counsellors in Feilding alone. Early intervention from Counsellors could prevent the downstream effect of large numbers of patients who end up being referred to Mental Health Services. Many GPs feel they do not have the specialised training to deal with the incipient mental health problems their patients bring to them. Many issues are family-related and labour intensive. This is particularly the case in low decile areas, where there is a great deal of anxiety and depression in the community, and unemployment, drug use and family

violence are common. GPs resort to giving medication for depression when they know that what is needed is a Counsellor. Neither is there a full subsidy for adults suffering from depression. The lack of support for GPs in dealing with these issues contributes to their prevalent feeling of disillusionment about their work.

The low morale of GPs is exacerbated by insufficient GPs in the district. While it is true to say that there is a nationwide shortage of GPs, this workforce situation is accentuated by GP destination preference for large cities like Auckland, Wellington and Christchurch.

Other skills shortages that the six GPs who were interviewed felt impacted on primary healthcare are:

- Podiatrists (severe shortage)
- Diabetes specialist nurses
- Asthma clinics
- Wound care specialist nurses
- Occupational therapists
- Speech therapists
- Dieticians.

There was no GP perceived problem in finding physiotherapists, and not a uniform need for midwives.

GPs referring patients to secondary healthcare providers at Palmerston North Hospital, under public funding, expressed concerns over a number of skills shortages that were impacting significantly on patient care. They felt that secondary care was dominated by the issue of accessibility, and that while public expectation was that most medical conditions will receive a prompt response, the providers' perception is that only acute cases are seen. Two GPs pointed out that there is a long waiting list (about six weeks' wait) for psychological assessment at Palmerston North Hospital. There is a 12-18 month waiting list for dermatology, waiting lists for vasectomies, varicose veins, haemorrhoids and tubular ligations, and shortages of cardiologist and neurologists. It is often difficult to get a second opinion from a secondary healthcare specialist because of accessibility issues.

Transport was again mentioned as a source of huge frustration and concern in rural areas. Patients from rural areas were seen to be disadvantaged in terms of ready access to secondary healthcare provision.

### **Responses from Maori Health Providers**

The four Maori Health Providers interviewed identified a shortage of GPs and Practice Nurses, and of Maori GPs and Practice Nurses in particular. The advent of Nurse Practitioners was welcomed as a future solution to some of these shortages in meeting Maori community need. Three Maori Health Providers mentioned the waiting lists for qualified Counsellors and the need to see Social Workers as part of primary healthcare provision. One Maori Primary Healthcare Provider stressed the need for staff with a knowledge of tikanga Maori and sympathetic to the kaupapa of the provider.

### **Responses from Community Based Mental Health Providers**

Both Mental Health Providers interviewed believe that there are not enough GPs and Practice Nurses with expertise in mental health. Both providers also believe that psychiatrists and mental health support workers need to be part of a primary healthcare service, even though they acknowledge there are insufficient trained psychiatrists in the workforce (four to six week wait to see a psychiatrist). The providers in the interview sample see the enormous benefits of this early intervention model for patients with potentially serious long term mental health problems.

### **Responses from Pharmacists**

All three Pharmacists in the interview sample believed that Pharmacists should be involved in Primary Health Organisations (PHOs) to make a valuable contribution to health promotion and understanding the needs of individual patients in the community. They believe that they are not given credit for the initial important contacts they make with members of the community because:

- They are seen as a referred service
- ‘Silo’ thinking about primary healthcare by the Ministry of Health contradicts the policy intent of PHOs.

Pharmacists refer patients to GPs, dentists and dermatologists, and are aware that there are skills shortages in cardiology and psychiatry.

### **Responses from Physiotherapists**

Both Physiotherapists interviewed worked with teams that had a good physiotherapy skills mix.

## **Responses from Practice Nurses**

One of the three Practice Nurses interviewed felt that there were not enough experienced Practice Nurses available. She also believes that nurses work too much in isolation from other health providers, and need more collaboration, with better co-ordination of primary and primary/secondary services. Funding restraints seem to play a large part in this. Another Practice Nurse in the interview sample felt that if gaps, such as Mental Health, were filled, there would be good coverage of skills in the district. Transport is seen as a big problem that prevents patients from accessing the available skills pool for secondary healthcare, based at Palmerston North. It was pointed out that the Tararua PHO needs these issues to be addressed if it is to be successful.

Skills shortages in secondary healthcare provision were identified as follows:

- Diabetes Nurse Specialists
- Respiratory Nurse Specialists
- Dieticians.

These specialist nurses are based in Palmerston North and have six-week waiting lists; although there are satellite clinics, the waiting lists are even longer (five to six months).

Of concern to Practice Nurses is the lack of liaison with respect to patient information. They believe that it would be preferable to have an individual wellness plan follow a patient through a primary-secondary-primary healthcare cycle. Also of concern is the protracted time taken to assess home help and assistance for patients. Elderly people are sometimes discharged with no follow-up about assistance at home.

## **Responses from other providers**

The indicative sample of one Midwife, one Diabetes Trust Manager and one Palliative Care Hospice Manager all reported skills shortages in their specific areas of primary healthcare. The Midwife stated that there was a national shortage of midwives and commented that retention of midwives is not good in the Palmerston North Hospital. The Diabetes Trust Manager stated that more involvement of GPs and Practice Nurses is needed in the treatment of diabetes and pointed out the need for more podiatrists: there is currently a seven month waiting list for the one podiatrist employed by MDHB across the whole district. The Palliative Care Hospice Manager believes that more training is needed for doctors in palliative care.

#### 4. USE OF INFORMATION TECHNOLOGY

##### **Responses from Dentists**

Most dentists are using information technology for patient records, recall, administration, dental benefits and accounts, although some dentists are still using hard copy claim forms. Work is duplicated when MDHB pro forma coversheets have to be filled in manually and the pro forma is completed electronically. The Internet is seen as useful for continuing education courses.

##### **Responses from GPs**

Five of the six GPs interviewed found that information technology was a useful tool in managing their practice, and used it for a number of purposes:

- Database of patients with details of age, gender and ethnicity
- ACC and GMS claims
- Cervical smears and vaccinations
- Scripts
- Recall details
- Access to Medline
- Access to CME online
- Access to Healthlink.

One practice has its own website and Intranet and all doctors have remote off-site access to the Internet and to computerised notes on a central database. X-ray and lab results are downloaded, and work is being done to download discharge notes. A pilot scheme has been mooted about sharing information between GPs and Pharmacists, with levels of access to protect confidentiality.

Three GPs saw that the success of PHOs was dependent on the sharing of information but expressed concern about how to establish responsibilities for patient results and follow-ups with referral. A swipe card system with notes was seen as a possibility – with the patient taking responsibility for sharing the notes. One GP had difficulty with the level of information sharing MDHB accepted. X rays were not shared, whereas discharge notes were.

One GP felt that the use of information technology provided a small return for initial implementation and ongoing operational costs. The benefit was seen to be

mainly for the Ministry of Health (MoH), ACC, MDHB, and Pharmac, and was a qualified success for patients.

### **Responses from Maori Health Providers**

All four Maori Health Providers interviewed used information technology and found it valuable for:

- Administration
- Accounting
- E-mails
- Contacts.

Two of the providers found MedTech32, a fully integrated prescribing and reference database, useful and were interested in the use of integrated notes with GPs and establishing different levels of access for health workers.

### **Responses from Community Based Mental Health Providers**

Of the two Mental Health Providers interviewed, one was beginning to use information technology through getting several practices to load three monthly recalls to improve risk management, and had received a mixed response on this initiative from several practices. The other provider felt that their organisation was a long way behind on the use of information technology. Being a Trust, the organisation had few resources and all files were still manual. The provider would welcome the opportunity to use information technology to allow easier monitoring and to establish links with other organisations.

### **Responses from Pharmacists**

All the Pharmacists interviewed agreed that they were well versed in information technology and have worked collectively for six or seven years to accumulate data to manage patient health better. They have structured, relational databases and are able to provide data to MDHB and GPs on medication dispensed. This could help to identify who are the high users of healthcare.

### **Responses from Physiotherapists**

The two Physiotherapists interviewed have well-developed information technology in their practices and use it for:

- Database for injuries and ACC claims
- Patient files and clinical notes
- Fees.

They would welcome selective sharing of information on patients coming to them through the hospital system, for example medical history, surgical notes, lab results and X rays.

### **Responses from Practice Nurses**

The Practice Nurses interviewed saw that healthcare providers needed to move beyond individual professional protection of information for information technology to work for the benefit of patients. Although they all work in fully computerised practices, they believe that communication between primary and secondary healthcare is still of a poor standard and that referral letters are not inclusive of information from all primary health carers involved in the care of a patient. Discharge notes from the hospital go to GPs and are not always shared with Practice Nurses who are responsible for the ongoing care of discharged patients. Education of the providers is the issue to be addressed for information technology to be truly useful.

### **Responses from other providers**

The indicative sample of one Midwife, one Diabetes Trust Manager and one Palliative Care Hospice Manager reported different levels of use of information technology. The Diabetes Trust Manager is hoping to have a local database of recall dates loaded in Palmerston North as soon as the databases are decentralised. The Palliative Care Hospice Manager has been using information technology for a year for administration, to gather statistics on community need, and to establish patient needs records. Discussions have taken place with MDHB about the sharing of records with GPs. At the moment, the Hospice is still receiving hand-written referral notes from GPs.

Midwifery business is essentially run from home, and so reporting is still mainly manual, although some Midwives use customised software for reporting, and access the HealthPAC online claiming system. Delivery suite bookings and the accessing of lab results and medical histories are done on hospital computers, and computers are used for letters and referrals.

## **5. CULTURALLY APPROPRIATE SERVICES**

### **Responses from Dentists**

The general response from the sample of dentists interviewed was that their staff are aware of a huge array of different cultures and that they work with sensitivity towards individuals, and focus on making patients feel comfortable.

Of the three dentists interviewed, one had a cultural safety policy, and pointed out that the Palmerston North Hospital Department did not have one when asked about theirs. This dental practice had great awareness of the head and mouth being tapu to Maori, and gave all patients extracted teeth to take home. A dental practice in Levin has a dentist who speaks Mandarin and some Cantonese, which has considerable cultural relevance for a local population which has a large Chinese component. One dentist expressed concern that Maori children are seen once and then frequently don't return for a dental appointment until they are adults, with dental problems.

### **Responses from GPs**

All of the GPs interviewed saw sensitivity to the dignity of individuals as being of paramount importance. Three of the GPs interviewed placed emphasis on the importance of being aware of cultural differences; one of these three GPs gave support to a Maori provider and one worked in a multicultural practice where the doctors themselves came from a range of cultural backgrounds.

One GP saw that cultural appropriateness was more an issue of quality primary healthcare, and another GP felt that Maori patients would benefit from home visits, which would be more culturally appropriate, but the pressure of work meant that this service was only offered for emergencies.

A GP in Otaki was concerned that the Medical Centre there is seen as being European, despite the population of Otaki being 30% Maori. There is no outreach service to maraes, and Te Runanga o Raukawa has no GPs. Hearing tests and contraceptive services are the only interface with the practice. Strategies for better interface need to be devised.

### **Responses from Maori Health Providers**

All four Maori Health Providers in the interview sample have Kaupapa Maori at the core of their service delivery philosophy. They have developed their own culturally appropriate models of practice. This is seen as important when Maori are a target group for the new Tararua PHO. One provider commented that it was difficult attending courses that were culturally inappropriate where the learning then had to be reinterpreted for Maori. Another provider commented that the culturally appropriate model of support that involved going out into the

community and bringing clients into clinics was difficult to achieve because of a difficulty with capacity and resources.

### **Responses from Mental Health Providers**

The two Mental Health Providers had different experiences of working with Maori. One provider has a partnership agreement with a Maori Primary Healthcare Provider and has always had input from the Maori Mental Health Unit at Palmerston North Hospital. This Mental Health Primary Healthcare Provider also acknowledged the work of the IPA on cultural awareness and relationship-building.

The other Mental Health Primary Healthcare Provider feels they are not getting sufficient referrals of Maori patients, and wonders if this is because of whanau care for Maori with mental illness.

### **Responses from Pharmacists**

One of the three Pharmacists in the interview sample includes consultation with iwi about provision of services as part of staff training, and is developing a Maori Health Plan. Another Pharmacist stated that the expectation of the local community was that pharmacies should have a cultural policy based on The Treaty. The third Pharmacist was of the view that the Pharmacist/customer relationship is based on professionalism and trust and is not a cultural issue.

### **Responses from Physiotherapists**

Both Physiotherapists interviewed feel that they practise with a good understanding of Treaty obligations and realise that there are issues of access and levels of comfort in receiving treatment. Informal networks exist with Maori Health Providers, and one Physiotherapist will soon be offering a consent form in Maori.

### **Responses from Practice Nurses**

The three Practice Nurses interviewed feel that their own practices are culturally appropriate and that they are very good at delivering care in an individualised and responsive manner. They perceive that the big gap in cultural awareness and safety lies in the GP body. The IPA is considering setting up training to address this issue.

### **Responses from other providers**

The indicative sample of one Midwife, one Diabetes Trust Manager and one

Palliative Care Hospice Manager all reported that they felt comfortable with the level of cultural appropriateness they showed in their work. The Midwife stated that an intrinsic part of midwifery training is facilitating decision-making that fits cultural need. Inclusiveness of family increases cultural levels of comfort, and Midwives are involved in a number of cultural initiatives for Maori, for example Tamariki Ora. Maori women go to both Pakeha and Maori Midwives.

The Diabetes Trust Manager has close links with the four main Maori Health Providers in the district and is a member of a Maori focus group think tank addressing heart and lung disease. The Palliative Care Hospice Manager feels that culturally appropriate services are delivered at the hospice, and there has been training for hospice staff to ensure that Maori feel very well supported. There is a need to document current hospice practices as part of a more formal approach to working with Maori patients.

## 6. POSSIBLE SOLUTIONS FOR HEALTH WORKFORCE DEVELOPMENT

### **Responses from Dentists**

All three dentists in the interview sample feel that the NZDA and local branch training and continuing education courses that are already available to them meet their needs. New techniques and ideas are made available, as are voluntary Internet continuing education modules. Two dentists expressed a wish to see MDHB be more proactive in bringing experienced clinicians to Palmerston North to provide seminars. One dentist wished to see block or correspondence courses provided for hygienists. A third dentist wished to tighten professional vetting controls on immigrant dentists to ensure quality control of services.

All the dentists interviewed acknowledged that it was difficult to recruit dentists to Palmerston North and rural locations. One general incentive they thought could be put in place was better communication and increased funding from MDHB, with less bureaucracy, to facilitate timeliness of contract processing and funding.

### **Responses from GPs**

All the GPs in the sample acknowledged the need for continuing medical education (CME), although finding time to keep up presented a challenge. It was felt that while there were some good training opportunities, it was important to recognise the importance of Research and Development in primary healthcare, most of which was taking place in tertiary training institutions. Sessions with specialists about the latest techniques would prove invaluable. Some of these should be held nearer to Otaki, to counterbalance all the courses held in

Palmerston North that many district GPs could not attend.

Two GPs expressed a wish to have some business training provided, and one GP felt that there should be lots of training in supervision to promote a healthier balance in lifestyle for GPs. Another GP felt that GPs in larger practices could learn a great deal from one another's complementary skills through modelling and mentoring.

A solution to the shortage of secondary healthcare specialists was offered by one GP who felt that training so as to be able to deal with varicose veins, basal carcinomas, and ganglions could be given to GPs so that they could undertake this section of medical care.

Several different solutions were offered to improve workforce development in the district. Innovative approaches to attracting doctors and nurses to the district were suggested, for example having a GP available in Palmerston North Hospital to work in a preventative fashion to keep nurses at work. Another suggestion was an incentive scheme to raise the morale of GPs and make them feel valued by providing a grant or subsidy for building Medical Centres as a reward for five years' rural service, and by bonding doctors from overseas to a period of rural service.

Funded or subsidised transport for secondary healthcare patients in rural areas was also seen as a solution to current health provision equity problems.

### **Responses from Maori Health Providers**

Two Maori Health Providers expressed concern at the low numbers of Maori nurses graduating. There was a view that the academic nature of the first year of training is a barrier to Maori nursing recruits, and a number of solutions were suggested:

- Offering papers in Te Reo
- Have second year nurses mentoring student nurses
- Mix academic and practical training in the first year
- Have kuia and kaumatua teaching cultural safety
- Acknowledgement of oral learning through oral examinations.

One provider suggested there should be more innovation around models of healthcare for Maori, for example larger Maori Health Providers could offer training in-house to ensure appropriate training provision, so that training the

trainer models would be hapu-based.

Another Maori Primary Healthcare Provider would like training in software packages and would like to see some incentives for staff working in rural areas. Several providers believe that health workforce development for Maori is dependent on increased funding for Maori Community Health Workers to promote wellness through proactive programmes of education.

### **Responses from Mental Health Providers**

Both Mental Health Providers interviewed felt that shared training for all organisations involved in the care of Mental Health patients would increase understandings and co-operation. They see an important role for MDHB in organising this training for relevant Non Government Organisations. By raising the profile of mental health provision, it would then be hoped that nursing in this sector would become more attractive and sustainable. The greatest current difficulty in recruiting is finding nurses for clinical on-call, house visiting and dual diagnosis (mental health, drug and alcohol addiction).

### **Responses from Pharmacists**

The Pharmacists interviewed agreed that continuing education is not attractive in the present industrial climate; there is little remuneration for the loss of working hours. Pharmacists feel that the ability to provide ongoing viable services is increasingly becoming a challenge, and that either fair and equitable funding should be provided, or real and actual costs should be passed on to the public. Recruitment and retention are major issues facing Pharmacists at this time, not only because of the attraction of overseas markets for young graduates, but also because Pharmacists feel undervalued in New Zealand. The three Pharmacists interviewed believe that adoption of the latest Pharmac proposal for three-monthly dispensing of prescriptions will lead to a huge workforce need in their skills area. Inclusion of Pharmacists in PHOs, to provide an integrated care model, would make recruitment to the area attractive.

### **Responses from Physiotherapists**

Suggestions from the Physiotherapists interviewed as to workforce development solutions were that MDHB:

- Bring in speakers to lift the skills base in the district
- Keep Physiotherapists in the information loop about relevant training sessions

- Systematise, plan and integrate contracting of services and quality management
- Look at waiting lists and decide who is not getting treatment for specialised branches of Physiotherapy e.g. hand-based physiotherapy or post mastectomy lymphoedema treatment
- Support initiatives with at risk groups (obese or diabetic patients or elderly patients at risk of falling)
- Use recruitment incentives like paying airfares to attract overseas Physiotherapists, paying bonuses for two year contracts and offering subsidised accommodation.

### **Responses from Practice Nurses**

Training is seen as a challenge for Practice Nurses because of the difficulty of obtaining release time from a busy practice, with training sessions often being held in the middle of the day. There are also difficulties with location accessibility issues. A preferable model might be to have specialist practitioners visiting practices to offer needs based training. There is a need for MDHB to visit rural areas to understand the challenges.

One Practice Nurse suggested that doctors and nurses should be trained together as a team, and also work together with secondary healthcare providers for a rationalised interface of patient care. It was suggested that better salaries would recognise the workload and responsibilities of Practice Nurses and would improve recruitment. A need for clear direction from the PHO committee as to expectations, and a need to set up clear audit trails, were seen as critical success factors for PHOs. One Practice Nurse mentioned her concern about the national shortage of Psychologists, Social Workers and Counsellors that was impinging on the health workforce capacity of the district.

### **Responses from other providers**

The indicative sample of one Midwife, one Diabetes Trust Manager and one Palliative Care Hospice Manager had different training needs. The Diabetes Trust Manager and the Palliative Care Hospice Manager would like to see GPs and nurses with specialist training in their areas of healthcare provision. The Palliative Care Hospice Manager believes that encouraging networking through training is a positive way of developing workforce capability through shared understandings. The Midwife who was interviewed believes that access to training is not an issue, but release time to attend is much more of an issue. All three providers mentioned increased funding and making the work environment

more attractive as incentives in improving health workforce recruitment and retention figures.

## **EQ2 - Perceptions of MidCentral DHB:**

To what extent does MidCentral DHB believe their current health providers meet, and can continue to meet, the needs of the community?

### **1. COMMUNITY NEED AND HEALTH PROVIDERS**

The view of MidCentral DHB (MDHB) managers mainly reflected the concerns expressed by the primary healthcare providers. In terms of Human Resources provision in secondary healthcare, the MDHB view is that the provision is adequate and does not put the community at risk. MDHB is not able to offer the whole gamut of specialist services in this district and is working to this end in collaboration with neighbouring DHBs. There is an acknowledgement that there are probably not enough GPs in rural areas. Within Palmerston North Hospital, senior nurses are leaving because of an environment and culture where they say staff are not supported and workloads are huge. MDHB is working through these issues, which are resulting in a disproportionate number of junior nurses. In secondary healthcare there is a perceived workforce shortage of radiologists, anaesthetists, physicians, and nurses in internal (non medical) medicine. There are difficulties with the skill mix of nurses in general; many nurses are older and are replaced by nurses with little experience.

In Mental Health, the Group Manager acknowledged that there is an issue with having a sufficiently skilled workforce and that it is difficult to recruit effectively in the district. Since 50% of the clients live outside Palmerston North, this becomes problematic. The Group Manager also acknowledged that Mental Health Providers probably have to carry a relatively higher load of work because of this.

The Nursing Director believes that the community wants access, coordination and consistency in primary healthcare, and that instead they encounter fragmentation and barriers to access. Nursing provision is perceived by the Nursing Director as being dictated by employer contracts and is seen as out-of-alignment with community need. Most primary healthcare providers are GPs, with a biomedicine view of healthcare, and determining and influencing the practice of other health providers. The Nursing Director believes that contracts are driven from a biomedicine point of view, for example a focus on funding for treating wounds instead of acknowledging the whole person or family. The prevalent concept is seen as one where medicine and nursing are competing, whereas nurses see themselves as collaborative workers. The Nursing Director states that research shows that 80 % of what GPs do can be safely and effectively done by nurses. Since only 11% of medical students are indicating an interest in

GP practice, the view of Practice Nurses and their capability needs to change.

The Medical Director believes that there is a reasonable match between resources and community need in secondary healthcare. This statement is corroborated by the Recruiting Officer for Registrars and House Staff who refers to a straightforward recruiting process and a more than 50% retention rate of staff. However the Medical Director expressed concern that experienced nursing staff who are leaving are replaced by less experienced nurses.

The Clinical Director Dental Services believes that while there is a good match of need and provision in primary dental healthcare at the moment, there is likely to be a shortage of dentists in the next 10 years, as well as a looming workforce shortage of dental therapists and hygienists. The dental therapists are an ageing workforce nationally. It is felt that this issue has not impacted on MDHB as much as on some other DHBs.

A Clinical Nurse Specialist working in a nurse-led service, dealing with diabetes, believes that there are holes in the provision across primary and secondary healthcare, resulting in a struggle to meet demand. Monthly outreach clinics are run in Foxton, Feilding and Dannevirke, and fortnightly in Otaki. Children are seen at three monthly intervals with direction and follow-up. Adolescents are more difficult to follow up; psychologists are needed to work with them. There is a shortage of Psychologists (a shortage of personnel and funding) for working with families. As a result of this, it is mainly patients with type two diabetes that don't have their needs met. There is also a shortage of nurses under the diabetes clinical team. The Waikato has a successful model of these nurses going to see GPs and working with Practice Nurses.

## 2. WORKLOAD WITH RESPECT TO POPULATION RATIO IN PRACTICE

The Medical Director stated that the nursing workload in secondary healthcare is huge, and time with patients is stretched to the limit with respect to patient interaction. This becomes much less of an issue with doctors, if all positions are filled. The Recruiting Officer for Registrars and House Officers agreed that doctors had enough time with patients, apart from peaks and busy times. The Medical Director said that Cardiologists and particularly renal specialists are needed.

Peer review and support are seen as a reasonably strong feature of the hospital for medical staff. There is a culture of peer review without formalisation. However, there is no debriefing or support for nurses in traumatic or violent situations, and this leads to dissatisfaction.

Locums are only brought in when a doctor, particularly a senior doctor, is overseas long-term. A pool of specialist locums is not available in New Zealand. A relief team of House Surgeons covers colleagues on leave and there is a roster for after hours work under the DHB contract.

There is no locum cover for nurses, and professional development and scholarships can't be taken up as a result.

The Clinical Director Dental Services considers that there is adequate time for each patient in secondary dental healthcare. The waiting list for general anaesthetic is no longer than six months, with an average wait of no more than six weeks, and for oral surgery is between nine and twelve months. There is no dental after hours cover, but there is a roster for oral surgery emergencies. Supervision is internal and informal; two senior dentists provide supervision for the registrar and house surgeon.

A Clinical Nurse Specialist makes enough time with each patient, which increases the waiting lists. Non-urgent new referrals are waiting for four weeks. Diabetes healthcare is provided by five clinical nurses, one physician, and an endocrinologist who has an ambulatory patient clinic.

There is a major problem with locum cover, which is managed within the team. The team is keen to second Practice Nurses for one day a week for a short time; this can help with locum cover. A Practice Nurse in Feilding has also done this. It provides good continuity for the patient, an educative role for the Practice Nurse and good work for primary/secondary interface. The Emergency Department and The Doctors provide after hours cover, but if the patient is a child, the paediatrician will follow up. Supervision is informal and internal. The Clinical Nurse Specialist is mentor to other members of the team.

### 3. SKILL MIX OF HEALTH PROVIDERS IN THE DISTRICT

Shortages in secondary healthcare skills bases were reported as follows:

- Shortage of psychiatrists, psychologists and nurses (particularly in rural areas) in Mental Health services. There are some perceived difficulties in the recruitment of psychologists for adult services that are related to job satisfaction
- Need to build capacity for nursing; the skill mix for nursing is impoverished and there is no workforce infrastructure in primary health care (no leadership, education framework, career pathway, no thinking time and no mentoring)

- There are no periodontists or endodontists in Palmerston North, and there is an increased workload on secondary care because of suspicion from dentists about government contracts that provide little reward for efforts. More money in the system would lower the threshold of restrictions on need levels, and early intervention would be cost saving
- Podiatrist based at Palmerston North Hospital has an overload of work; peripheral vascular disease and diabetes are the priority
- The renal unit is overwhelmed
- A Social Worker, possibly a Counsellor, is needed as part of the diabetes team, for cognitive behaviour therapy
- Dieticians are poorly resourced to support the diabetes team.

#### 4. GOOD EMPLOYER MEASURES TO ENSURE RECRUITMENT AND RETENTION OF HEALTH PROVIDERS

MDHB is looking at developing a better work environment for staff, working with staff, unions and delegates to identify areas to improve the work environment and achieve a healthy work and life balance for all staff. Attracting staff to rural areas is a problem. It is difficult to find peer review support and opportunities for upskilling since Palmerston North is not a teaching hospital. Branding Palmerston North and positive marketing of Manawatu are recruitment strategies. MDHB is looking at recruiting from overseas and sharing a position around different DHBs.

A set of core values is being developed to help improve retention rates. These values will flow through to job descriptions. The way in which different groups work together will be considered for each area. Retention is not necessarily a salary issue. MDHB wants to stay in contact with New Zealanders who go overseas (to possibly attract them back) as well as creating flexibility for working hours and giving a package/CD of information on MDHB.

In general, MDHB perceives itself as an employer with good focus on employee well being and good intentions with respect to employment. Current management believes in investment in the workforce.

Young doctors coming through training now see their work as a profession rather than a vocation, and want a more balanced life. They are offered a good social life in Palmerston North, with good, cheap accommodation.

MDHB has protected conditions at the hospital (for example 12 weeks holiday)

and has worked at providing a congenial work environment to attract dentists. There is a national problem recruiting dental therapists and dentists; young graduates will often go overseas to find high earnings to repay debt. An ageing workforce will pose problems in dental therapy because a limited career pathway is not attracting new recruits.

New nurses are not prepared for specialist work in Mental Health in the secondary healthcare sector. They need preceptorship that makes a difference to the choices made at the point of graduation. It is important that student nurses acquire more of the skills needed for Mental Health work in training, for example, carrying a case load. Nurses are accountable for service delivery in the primary and secondary health sectors but have no power, resources, tools or leadership and management development needed to make them feel and be totally effective.

Recruitment is not a huge issue in diabetes healthcare because retention is good. Staff working in this area feel well supported by MDHB in continuing education, for example working towards Nurse Practitioner status, but it is still difficult to release more than one nurse at any one time.

## 5. CULTURALLY APPROPRIATE SERVICES

The following was reported by MDHB managers interviewed:

- There is a Maori Health Unit that works throughout MDHB in secondary healthcare with Manawhenua Hauora and the Maori Mental Health Unit. There is difficulty recruiting for this unit, which is possibly not best placed with MDHB.
- Registrars and House Surgeons are offered sessions on The Treaty as part of Human Resources training and have legislative compliance information in their induction packs
- Training for nurses is very rigorous about cultural safety. Then nurses move into an environment where cultural safety is not appreciated and some nurses were trained before this was an issue. There is a scarcity of Maori health personnel in MDHB, which has a 15% Maori population. Many Maori nurses see the Bachelor of Nursing as unattainable, despite huge efforts to support them
- In secondary dental health services everyone is treated with respect and dignity. The New Zealand Maori Dental Association is trying to encourage more Maori dentists
- There are too few Mental Health workers for Maori services, with only 2% of the national workforce of psychologists being Maori. The

opportunity for self determination of services by Maori is a big area still to be developed. In secondary care, as opposed to primary, Mental Health workers need to be qualified as clinicians.

## 6. POSSIBLE SOLUTIONS FOR HEALTH WORKFORCE DEVELOPMENT

Better links between the primary and secondary interface are perceived as being a major factor in health workforce development. There is also a need to consider the public/private interface, which affects the viability of income generation. The size of the city means that there is still considerable goodwill between primary and secondary healthcare, and this needs to be harnessed.

Investing in running time management courses would be helpful for all Registrars and House Officers, and would improve the service to clients as well as cutting down overtime. Many are overseas doctors who need to have better time management.

Nursing should benefit enormously from the PHS nursing development team, a funded pilot scheme, with an education development plan within it. Nurse Practitioners are building a critical mass to meet workforce needs.

Dental primary healthcare issues are more to do with the adequacy of supply of dental therapists. There are still questions to be asked about the training of dental therapists; one training organisation is more academic than the other. Upgrading the diploma to degree level could be a recruitment barrier. Within the hospital there will need to be an increase in distance education online link ups so that centres are sharing skills and approaches. This training has so far developed in an ad hoc manner.

There are a number of possible solutions to workforce development in Mental Health. Developing staff in a culture that follows a more collaborative model for service provision and providing training for that model is essential. This means working across perceived boundaries between primary and secondary and breaking down perceived barriers within secondary healthcare. An important step to take in this regard is to open up training for secondary mental healthcare to primary healthcare providers and giving secondary healthcare personnel the opportunity to work with providers in primary healthcare, to support them. It is also most important to have good relationships with training providers and to exchange skills with other sectors, for example police and volunteer caregivers in the social work area.

With the development of PHOs, there is a need to think more about the primary healthcare objectives and work on coordinated healthcare for diabetes, to

produce an integrated model of care based on 'multiple pathology' needs (patients who suffer from more than one disease) and a multi disciplinary approach. A paper is needed in New Zealand at Masters level for diabetes specific education to encourage high-level training in this area.

### **EQ3 – Perceptions of Professional Organisations & Training Institutions:**

To what extent do professional organisations and employment agencies believe that the current and future predicted health workforce can meet and can continue to meet the needs of the community?

This part of the report is incomplete due to the very poor response rates from the professional organisations and training institutions that were approached. Adequate and comprehensive response has only been received from the Dental Council of New Zealand and their information is presented in the remainder of this section.

The CEO of the Dental Council of New Zealand reported that only 50% of the population accesses dental care on a regular basis. There is a clear maldistribution of dentists across the country, for example in Auckland DHB there is a ratio of 96.4 dentist FTEs per 100,000 population (aged 14 years and above), whereas the West Coast has 16 dentist FTEs per 100,000 population. This statistic is indicative of skills shortages in rural New Zealand. Currently the Dental Council of New Zealand is registering as many immigrant dentists as newly qualified New Zealand dentists. A complicating factor is the selection criteria at Otago Dental School which have only been based up till now on academic ability. There is an intention to introduce communication and motivation skills in future.

Dental workforce capacity has suffered from the loss of some graduates returning to their country of origin. There is no career pathway for dental therapists; the preference is to become dental hygienists. The workforce situation in this respect may soon improve, with the ability (under the Health Practitioners Competency Act) for dental therapists to set up a practice (similar to Nurse Practitioners).

It is preferable for dentists and dental therapists with DHB contracts to be part of PHOs, thus giving a more holistic view of a patient's health. Possibly overseas dentists can be accepted as dental therapists in New Zealand. Since 40% of dentists in primary healthcare are sole practitioners, they will need peer review support under the Health Practitioners Competency Act, and this will assist with any competency issues and provide continuing performance development.

Communication and informed consent are issues with the public with respect to bicultural and cross-cultural issues. Training in the 5th year of dentistry has improved the integration of these skills.

Even though there is an increase in retention rates of dentists, in real terms, mainly because of an increase in women dentists, it is important to realise that this doesn't meet FTE statistics. This larger proportion of women is under 40 years of age, perhaps involved in bringing up their own families, and tending to work only 0.89 FTE.

## 6. EVALUATOR'S COMMENTS

There are a number of fundamental issues underpinning the findings in this report. It would be all too easy to blame remote factors outside our control for workforce shortages, for instance saying there are international, and therefore national shortages of doctors, nurses and dentists, and that these things are beyond our control. Equally, it is all too easy to lay blame close to home, saying the Ministry or DHB have not planned sufficiently well, are not prioritising their funding to meet community need, or are not funding equitably within a provider area.

A more constructive approach is to accept what we cannot change immediately, appreciate that the DHB has constraints placed upon it by the Ministry of Health and other key players in the politics of Health, and work towards better provision to meet analysed need. Part of this constructive approach has to be the continuing education of policy makers by the healthcare providers who work at a pragmatic level.

This report presents findings based on the views of these healthcare providers. The single most important finding is fiscally neutral. It is that better communication is required from all stakeholders in the process of MDHB primary and secondary health provision. In this way PHOs can evolve with professional sharing of information about patients to provide a more holistic model of individual care, primary providers who can make a valuable contribution to PHOs can be included, patients can be assured of a GP who knows them and works with others to provide the best care possible, GPs are supported in their work by trained Counsellors to offset patients' potential mental health problems, Nurses are recognised for the full range of their considerable skills, Maori providers work with non-Maori providers to find ways of making existing services more acceptable to Maori and using them fully, and the interface between primary and secondary healthcare allows smooth transition of care for patients.

In order to enhance healthcare through these permutations of improved communication, MDHB has a pivotal role to play. It can broker many of these interactions, but first of all it must put in place better mechanisms for continuing to update itself on the views of its providers, so that the work of this report becomes the basis for continued good communication between MDHB and all of its providers.

Most interviewees see better liaison between MDHB and themselves as the solution in itself to addressing workforce development needs. It is certainly the mechanism to do so. Only then can the most fundamental issue of all be addressed – a focus on community wellness.

## Bibliography

- The New Zealand Health Workforce: A Stocktake of Issues and Capacity 2001; Health and Workforce Advisory Committee; April 2002
- The New Zealand Health Workforce: Framing Future Directions Discussion Document; Health and Workforce Advisory Committee; October 2002
- Investing in Health; Report to the Ministry of Health From The Expert Advisory Group on Primary Health Care Nursing; March 2003
- Whakatataka; Ministry of Health; November 2002
- He Korowai Oranga; Ministry of Health; November 2002
- District Annual Plan 2002/2003: MidCentral District Health Board; December 2002
- District Annual Report 2002, MidCentral District Health Board
- 2002 Workforce Analysis; Dental Council of New Zealand; May 2003
- The New Zealand Medical Workforce in 2001; Medical Council of New Zealand; February 2003
- The Medical Council of New Zealand. Enable New Zealand. The New Zealand Medical Association. MidCentral DHB  
<http://www.access.org.nz/links.htm>
- Corporate Profile of Whakapai Hauora; Whakapai Hauora Charitable Trust; 2003
- MidCentral DHB, <http://www.midcentral.co.nz>
- MidCentral District Health Board General Information regional basis, covering other DHB districts  
<http://www.midcentral.co.nz/MDHB/MDHB-Info.htm>
- MOH: Nurse Practitioners in New Zealand  
<http://www.moh.govt.nz/moh.nsf>
- District Health Board jobs for Nurses in New Zealand  
<http://www.nursy.com/Districthealthtxtjobs.htm>

- **District Health Board vacancies in New Zealand**  
<http://www.geocities.com/hotsprings/2271/Districthealthtxtjobs.htm>
- **New Zealand Government and Agencies. Alcohol Advisory Council, New Zealand. Non-Government Health and Science Sites**  
<http://www.hrc.govt.nz/sites.htm>

## **Appendix A: List of Evaluative and Investigative Questions Used in the Interviews**

### **Evaluative Questions**

- EQ1** To what extent do the current health providers for MidCentral DHB feel they meet, and can continue to meet, the needs of the community?
- EQ2** To what extent does MidCentral DHB believe their current health providers meet, and can continue to meet, the needs of the community?
- EQ3** To what extent do professional organisations, relevant educational institutions and employment agencies believe that the current and future predicted health workforce can meet and continue to meet the needs of the community?

### **Investigative Questions**

For each evaluative question, there were seven investigative questions.

- EQ1** To what extent do the current health providers for MidCentral DHB feel they meet, and can continue to meet, the needs of the community?
- IQ1.1** Does the workforce to population ratio in your practice create a reasonable workload with respect to: adequate time with each patient, team practice support, sufficient locum cover, sufficient after hours cover, sufficient supervision/peer review?
- IQ1.2** To what extent do you have practice team support?
- IQ1.3** To what extent do you feel there is a sufficient skill mix of health providers in the district to provide an integrated 'model of care' approach and to what extent, therefore, are you able to refer patients to other primary and secondary care providers?
- IQ1.4** To what extent do you find the use of technology helps you in your practice, if at all?

- IQ1.5 To what extent are you able to deliver culturally appropriate services in the district?
- IQ1.6 What training would help you most in your work for the future?
- IQ1.7 Do you have a view on possible solutions for health workforce development in the district?

**EQ2** To what extent does MidCentral DHB believe their current health providers meet, and can continue to meet, the needs of the community?

- IQ2.1 Do you consider that community need is currently matched with the appropriate proportion of health providers in your district?
- IQ2.2 Do you feel the workforce to population ratio in your district creates a reasonable workload for health providers with respect to: adequate time with each patient, sufficient locum cover, sufficient after hours cover, sufficient supervision/peer review?
- IQ2.3 Do you feel there is a sufficient skill mix of health providers in the district to provide an integrated 'model of care' approach?
- IQ2.4 What good employer measures does MidCentral DHB put in place to ensure recruitment and retention of health providers?
- IQ2.5 To what extent do health providers deliver culturally appropriate services in the district?
- IQ2.6 What training needs do you believe are the most essential for the perceived future health needs of the community?
- IQ2.7 Do you have a view on possible solutions for health workforce development in the district?

**EQ3** To what extent do professional organisations and employment agencies believe that the current and future predicted health workforce can meet and can continue to meet the needs of the community?

- IQ3.1 Do you consider that community need is currently matched with the appropriate proportion of health providers nationally and in provincial areas?

- IQ3.2** Do you feel the workforce to population ratio nationally and in provincial areas creates a reasonable workload for health providers with respect to: adequate time with each patient, sufficient locum cover, sufficient after hours cover, sufficient supervision/peer review?
- IQ3.3** Do you feel there is a sufficient skill mix of health providers nationally and in provincial areas to provide an integrated 'model of care' approach?
- IQ3.4** What are the main issues impinging on recruitment and retention nationally and in provincial areas?
- IQ3.5** To what extent do health providers deliver culturally appropriate services nationally and in provincial areas?
- IQ3.6** What training needs do you believe are the most essential for the perceived future health needs of communities?
- IQ3.7** Do you have a view on possible solutions for health workforce development in the district?

### **Confidentiality of Information**

Evaluation practice will be in keeping with the ethical principles and associated procedures endorsed in the Australasian Evaluation Society's Guidelines for the Ethical Conduct of Evaluations. Stakeholders who participate in the evaluation will not be identified individually with respect to the information they provide. The data analysis and final report will group information and findings according to the role of personnel interviewed.

## **Appendix B: List of Interviewees**

### **MidCentral DHB:**

- HR Group Manager
- Medical Director
- Clinical Director Dental
- Director of Nursing
- Clinical Nurse Specialist
- Group Manager, Mental Health
- Recruiting Officer: Registrars and House Surgeons.

### **Primary Health Care Providers in the district:**

- 6 GPs covering urban and rural areas
- 3 Dentists covering urban and rural areas
- 4 Practice Nurses
- 4 Maori providers
- 3 Community pharmacy services: 1 rural, 2 urban
- 2 Physiotherapists
- 2 Mental Health Providers
- 1 Manager Diabetes Trust
- 1 Midwife
- 1 Manager Palliative Care Hospice.



CentralRegion TAS Limited  
PO Box 23 075  
Wellington

Phone 04 495 4400  
Fax 04 460 4937