Universities New Zealand Briefing to the Incoming Minister of Health

Universities New Zealand is pleased to congratulate you on your appointment as Minister of Health.

This briefing is prepared by Universities New Zealand – Te Pōkai Tara[1] on behalf of the eight universities. The briefing identifies several areas where universities would be keen to engage with you.

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Health and the university sector

You are, of course, very familiar with the university sector from your time as spokesperson for tertiary education, skills, and employment.

Universities have a close relationship with the heath system. We generate a large number of the qualified skilled people required by the health workforce every year and we provide a large proportion of the upskilling, reskilling, and skills maintenance required across the 250,000 or so people that make up the health workforce.

There are three things we would like you to be aware of or to consider as you take up your new portfolio.

1. Universities are ready to do more to address health workforce needs

The pandemic has exacerbated pressure across the health workforce with staff and skill shortages, including specialist doctors, GPs, nurses and other clinical practitioners. Global competition for skilled health professionals has never been higher.

While developed under the previous Government, Te Whatu Ora's Health Workforce Plan (July 2023), provides a reasonable estimate of the gaps in the current workforce and the future workforce needs of the country.

Whether or not Te Whatu Ora's Health Workforce Plan is adopted by the incoming Government, New Zealand needs a holistic health workforce plan developed in partnership between the health and tertiary education sector. By working genuinely and openly, acknowledging the constraints and realities, and thinking laterally, this partnership would enable us to ensure that the right things are tackled in the right way.

[1] Universities NZ is the operating name of the New Zealand Vice-Chancellors' Committee, a body established under Part 19 of the Education Act 1989. It has statutory responsibilities for university quality assurance, the approval and accreditation of university academic programmes, entrance to universities, and scholarships. It also represents the interests of the universities on a wide range of other matters, such as education and research policies.

We wrote to you in June 2022 and shared our advice as to where the university sector could do more to address health workforce needs across all areas other than medicine.

The advice is appended to this briefing, and we remain committed to working with you and your officials on the recommendations.

2. Clinical Psychology

One specific area of focus around health workforce needs at present is meeting Te Whatu Ora's goal of doubling the number of clinical psychologists in the workforce. Achieving this target would require a 214% increase in student numbers.

Universities are very willing to increase student numbers and report high demand from students, but we are unable to satisfy demand because Tertiary Education Commission funding for these programmes does not adequately cover the costs of delivering the programme. Universities are currently cross-subsidising clinical psychology programmes from other areas and, in the current funding environment, cannot extend these subsidies further.

We recommend that you work with the Minister of Education to seek a reclassification of clinical psychology into a DQ7+ (previously SAC) cost category that better reflects actual costs in producing capable graduates.

3. University research supporting health outcomes

The university sector is a key source of research for our health system. For example, around $71m of the $124m administered by the Health Research Council for the year to 30 June 2022 went to fund 685 separate contracts across our universities.

Universities can do more to support your priorities for an effective health system. For example, we can do more to advance the country's priorities in areas such as infectious diseases, wellbeing, aging, and medical technologies.

We can also contribute more to health policy development, implementation, and evaluation. We are involved in Te Whatu Ora's new academic engagement programme and work with all Departmental Chief Science Advisors. However, universities research could be better utilised by the healthcare sector to ensure better health care delivery.

4. Higher Education Funding Review

The previous Government announced a Review of Higher Education Funding. The intention was for the Ministry of Education to provide the Minister of Education with a briefing on the potential scope of a review towards the end of 2023 and, if there was support for the review proceeding, to carry it out in 2024.

Though a Review of Higher Education Funding will not be a direct priority for you, it has potential to impact the health system. For example:

a. Funding for tools and systems that will address bottlenecks caused by work-placement requirements of some qualifications – particularly in fields such as nursing, clinical psychology, and social work.

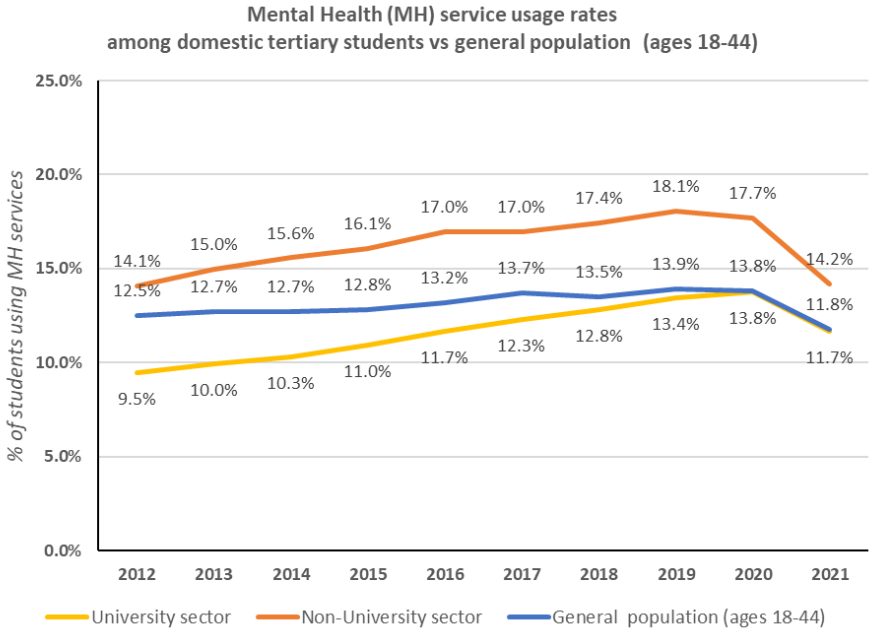
b. Addressing historical anomalies in DQ7+ (previously SAC) funding. There are some subjects that have been in their current DQ7+ funding category for 30 years, but professional

registration requirements and rising clinical access costs (charged to universities by both public and private health providers) now mean that funding in that category is inadequate. We are recommending that a small number of subjects move to more appropriate funding categories. Key areas this affects include social work, counselling, physiotherapy, medical laboratory science, medical radiation therapy, and educational psychology.

c. Additional funding to bring traditionally underrepresented parts of the population successfully into and through university. Māori and Pacific are traditionally underrepresented at university and are therefore underrepresented in health workforce roles that require degree-level qualifications. We can address ensuring systemic inequity with better investment in this area.

5. Universities are themselves dealing with mental health challenges.

The Integrated Data Infrastructure provides information on the proportion of tertiary students who accessed mental health and addiction services or treatments. This is mapped in the graph below, which shows that mental health service usage rates for university students have been above that of the general population, but below rates for non-university sector domestic students.



Source: Universities NZ 2023, extracted from IDI (Integrated Data Infrastructure).

All universities have been individually and collectively working to address the general upwards trend in mental health needs in line with expectations of the Education (Pastoral Care of Tertiary and International Learners) Code of Practice 2021.

For example, expenditure on university counselling services rose from $14.9m in 2013 to $18.9m in 2020 (27% increase).

The sector has been receiving additional support through Tertiary Wellbeing Funding that will provide $10m a year from 2024 onwards. This funding has been warmly welcomed and is making a substantial contribution to addressing real pressures around student wellbeing and mental health.

However, there continue to be challenges around the ability to access community health services when we have students experiencing severe or extreme mental distress. We are continually experiencing situations where the health sector refuses to accept these students because of a lack of capacity to support them.

Universities are neither mandated nor resourced to provide the support necessary for these students and this is creating an unacceptable level of risk both for the students and their university.

Attachment – Opportunities for the University Sector to assist with health workforce development *(previously provided to you in June 2022)*

We need a holistic workforce plan that addresses the following issues and constraints in the health workforce. This holistic workforce plan can only be realised through greater coordination between health and education, and by changes to policy and Government investment settings.

Challenges & issues	What would be in the holistic workforce plan
1 **Improving guidance and flexibility in health workforce development**. The health system is built around developing people over long periods to be successful in one area. They can develop in that area (for example; upskilling from being an enrolled nurse, to registered nurse, to nurse practitioner), but it is hard to move from that area to other roles. This sequential approach to developing specialists requires a long lead time and that makes workforce planning difficult. For example, it takes 14 years to produce a fully qualified specialist doctor. The system needs more flexibility for staff to move across the system more easily and more entry points for people to use relevant skills and experience to reduce the time to take up roles.	Provide clear but flexible pathways into health roles. • <u>For students looking at undergraduate degree-level health education</u>. Extend the model already in place at some universities where students complete at least one year of undergraduate studies before they are confirmed in a health specialisation. A proportion of students start with a clear intention of what they want to do (for example, nursing, midwifery, etc) so they should have some certainty of entry to their preferred specialisation at the start of studies, but with the ability to change. • <u>For students who are already degree-qualified</u>. Provide more graduate entry pathways to health sector roles – where (typically non-health related) undergraduate qualifications progress to shorter postgraduate qualifications in a range of health specialisations. • <u>For other areas - particularly allied health</u> (areas such as paramedicine, podiatry, and perioperative support). Recognise that students are looking for roles where they can serve their communities but often lack much academic preparation. These students will benefit from understanding the options open to them but will need practical wraparound support to pursue one option successfully through to completion. • <u>Ensure health professionals are operating at the peak of their profession</u>, not doing work that others could do e.g. extended roles for nurses, pharmacists, optometrists etc
2 **Better supporting students to get to roles that will best fit their aspirations and abilities.** The health sector encompasses a vast range of roles. Some of those entering it don't fully understand all the options open to them and need time to learn that health is more than just doctors, nurses, and dentists and to understand the pathways that will be best for them. Some want to serve their community in allied health-type roles and just need support and pathways that will unlock the value they can offer. Others already have significant qualifications and experience and need to understand the pathways that provide the most efficient and effective ways of moving into different roles.	
3 **Addressing clinical placements as the key constraint in health education**. The education pipeline has four potential choke points: (1) numbers of students interested in roles such as doctor, nurse, and pharmacist,	• <u>Health strategies</u> need to make it clear that clinical supervision and workforce development are key roles for health providers in delivering an effective health system. • <u>Redesign the clinical placement system nationally</u> to manage or reduce current constraints. We suggest: ○ Introducing a single national clinical placement framework (web-based system)

(2) DQ7+ (SAC)[2] funded places at a tertiary institution,

(3) clinical placements to give students the required practical experience for registration and employment, and

(4) employer demand.

In general, employer demand exceeds student supply. There are some issues around student demand and DQ7+ (SAC) funded places, but the main current choke point is the capacity and willingness of the health sector to offer and supervise clinical placements.

4 **Addressing attrition associated with clinical placements**. Clinical placements see a disproportionate number of otherwise capable students quitting their studies. In an already overburdened health system, people doing clinical supervision are often overloaded and lack time and training to support students placed with them. Many students are also wanting to work with their communities in whānau and community settings – not the traditional health provider settings they are placed in. In its current form, the clinical placement experience is causing students to discontinue their plans to work in health.

5 **Reducing the administrative overhead of clinical placements**. Clinical placements are largely done manually with every single student requiring their own MOU between the education provider and the health provider. They rely overly on the education provider having a wide range of networks across health providers to generate placement opportunities. Networks are more likely and more effective when providers are able to have clinicians on the teaching workforce.

6 **Address clinical access costs**. Tertiary institutions are required to pay health providers for clinical training access in many settings; there is little consistency in these costs, and in many cases, they absorb a significant portion of funding and/or have increased at a greater rate than DQ7+ funding.

to better match placement options with available students. A clinical placement framework could assist in identifying and managing take up of all available places – so there are students being rotated around 24/7 and a large amount of bureaucracy can be automated.

- Testing the requirements for placements to ensure they are still sensible. For example, New Zealand requires nurses to do 1,100 hours of placements as a condition of registration where Australia requires just 840 hours.
- Reducing some of the requirements for clinical placement hours by getting regulatory bodies to accept the role well designed simulations can play. Evidence shows that simulations improve patient safety, improve practitioner confidence, and enhance inter-professional and team-based work.
- Reduce some of the administrative impact of placements by supporting clinicians with health administrators.
- Require Heath NZ and Māori Health Authority to have supervision as a core part of business

- <u>Look at additional types of clinical placements</u> – particularly whānau and community-based placements for students aiming to work in those areas longer term. Augment this with wraparound support for students with particular cultural needs. (See section on wraparound support below).
- <u>Consider paid internships for clinical placements from the third year of studies onwards</u>. Student course load is high by this stage and students are unable to work while studying. International evidence also shows employers are likely to invest more time and effort in supporting internships when they pay interns a wage. Paid internships would help students through their studies while also contributing to an improved clinical placement experience.
- <u>Education providers need to be at the table for all health system workforce planning</u>.
  - The health system should be looking to universities for more than just workforce

[2] The Government's Student Assistance Component tuition subsidy – administered by the Tertiary Education Commission.

		training – they should be looking for what universities can provide in research and insights to understand evolving international practice, domestic requirements, and what is and is not working. o Universities can help identify evolving new demands in the health workforce – for example, evolving needs in areas such as rehabilitation, community-based work, and supporting patients through the health system and its choices.
7	**Supporting an increasingly diverse range of students through to employment.** The current funding system is not delivering equitable outcomes for Māori students, Pacific students and/or first in family students. There are many highly capable people in the health workforce who are not developing into more specialised roles due to lack of wraparound support to fulfil registration requirements.	• <u>Provide extra funding for wraparound support to Māori students and Pacific students</u> – particularly those 'first in family' to university: o Support school students from Year 9 to understand the importance of learning science, te Reo, English. o Extra culturally relevant support in first year. o Culturally relevant support and safe learning and teaching spaces for clinical placements – particularly where placements are not in traditional settings such as with whānau or the community. o Reinstate postgraduate student allowances so students without significant financial support from families are not having to choose between borrowing, working and/or studying.
8	**Supporting people from overseas into the health workforce**. At present people coming from overseas are frequently required to spend significant time and money doing additional training before they can work in this country. We don't adequately assess skills and knowledge to determine if the additional training is warranted.	• Provide clear and supported <u>pathways to residency for international students interested in studying health</u> in New Zealand and staying on to work here. • <u>Simplify pathways to accreditation for health workers with qualifications gained overseas</u>. Use evidence portfolios, testing, and monitored placements to assess knowledge and experience and have recognition of prior learning and credit transfer policies that avoid any unnecessary time and cost in accreditation.
9	**Supporting a more flexible health workforce**. Blur boundaries where sensible. Regulatory settings and professional bodies define and enforce hard boundaries around what particular roles can and cannot do. For example, professional bodies specify retraining requirements for health staff recruited offshore. This can require a significantly higher level of retraining than comparable other jurisdictions (such as the UK or Australia require) recruiting from the same markets. It	• <u>Increase workforce flexibility</u>. Take a comprehensive look at the common tasks that occur across the health system and identify ones that could be done safely and effectively by other roles with appropriate training and experience. This might allow more flexibility in which roles are allowed to diagnose, determine treatment, and to prescribe. It could require regulatory change and/or support from professional bodies.

	can also be overly prescriptive – for example, requiring training to be face to face where other jurisdictions allow distance and hybrid models.	• Support regulatory bodies in communicating the pros and cons of different options to the communities they consult when proposing changes. Recognise that these regulators are legally obliged to listen to and to reflect the views of those communities.
10	**Addressing policy and funding settings**. The funding system is creating constraints in some areas. For example, the number of medical doctor placements funded at universities is not meeting industry demand. Around 40% of the medical doctor workforce and 25% of the nursing workforce is trained overseas. These workers often lack an understanding of how to work effectively within the Aotearoa New Zealand context – e.g., with Māori and Pacific peoples. They are also less likely to remain in this country long term.	• Another DQ7+ (SAC) funding level to support clinical placements. Health providers require funding to manage clinical placements. For example, in the Auckland region a placement for a nurse is typically $25 a day while they complete 1,100 hours over the 2–3 years it takes to complete a nursing qualification. A placement for a midwifery student is typically $35 a day while they complete the 2,500 hours required over the four-year qualification. At present, the DQ7+ funding system is capped at two levels for nurse training, medical imaging, occupational therapy, midwifery, physiotherapy, speech and language therapy, medical laboratory science, pharmacy, medical radiation therapy, dentistry, and general medicine. All these need a third level to cover the extra costs while students are on clinical placements. • Increase DQ7+-funded places for subjects where domestic supply is not satisfying employer demand. Increase DQ7+ funding to allow for training of more students in areas such as medicine and nursing where we are currently overly reliant on overseas recruitment to meet workforce needs. • Rural delivery of teaching and learning. Consider multi-institutional rural delivery of teaching and learning for all health specialisations. In addition to being cost effective, it is likely to be more effective in supporting rural health needs. For example, 34% of Māori primary care practices are rural and this would improve their ability to meet skills needs. • Offer more in-work training and education to support movement within and across different parts of the health workforce. DQ7+ funding needs to be able to better support degree-level work-based teaching and learning modes. This is a significantly more expensive model than campus-based or work-integrated (blended) modes. • Clear pathways for health workers to progress in their specialisation. Establish clear pathways for students who complete certificate-level and

	other non-university qualifications in fields such as nursing to progress easily to postgraduate qualifications if they choose to specialise. For example, this would see clear pathways from Te Pūkenga undergraduate nursing qualifications to university postgraduate nursing qualifications. • Offer conjoint degrees (getting two degrees simultaneously in less time than it would take to complete them concurrently). This could help health professionals wanting to work in more isolated areas where, for example, there might be insufficient work for someone who is solely a midwife or a nurse practitioner, but enough for someone qualified as both a nurse practitioner and a midwife.