

Health Workforce Planning

an urgent need to link islands of expertise

Abstract

This article provides a snapshot of the legislative framework for, and ministries and agencies involved in or with influence over, the education of the health and disability workforce, including examples of disconnection between the wider health and education sectors. Particular challenges occur between health professional regulators, education providers and clinical (placement) providers because their respective areas of expertise tend to be siloed, thus reducing the capacity for a coordinated and holistic perspective. Four potential 'bridges' for linking these 'islands' of expertise are suggested. The current period of institutional reforms in the health and education sectors presents an opportunity to refine the structures and systems for workforce education and planning, thereby facilitating a more flexible, responsive and resilient workforce which is better equipped to engage with, and improve outcomes for, the wider community.

Keywords health workforce, health and disability, system transformation, education reform

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The complex landscape

The education of the health and disability workforce sits at the nexus of the health and education sectors, both of which are largely centrally funded, regulated and monitored. This gives rise to a range of professional scopes, boundaries and systems, including quality assurance and policy. Educational institutions providing health professional education must comply with multi-agency requirements across both the education and health sectors.

Under the Health Practitioners Competence Assurance Act 2003, 'responsible authorities' are established to regulate professions and protect the public from harm. Regulated professions include medicine, dentistry, nursing and midwifery, and a wide range of allied health professions such as pharmacy, chiropractic, occupational therapy, oral health, osteopathy, paramedicine, physiotherapy, psychology and psychotherapy, and more. The Act outlines a number of functions for responsible authorities, including involvement in education programmes leading to registration in the scopes of practice they oversee. This legislation is administered by the Ministry of Health – Manatū Hauora, which is also

charged with providing support for the government to comply with international obligations and administering approximately 30 pieces of domestic legislation.

The current health and disability system transformation has seen the disestablishment of 20 district health boards, replacing them with two national agencies (Te Whatu Ora – Health New Zealand and Te Aka Whai Ora, the Māori Health Authority) that work alongside the Ministry of Health and the newly established Whaikaha – Ministry of Disabled People. Health professionals, organisations, professional bodies and responsible authorities are all currently navigating the changes to the health and disability sector.

Any interest in health professional education that responsible authorities may enact occurs within the context of a range of tertiary education quality assurance requirements overseen by the Ministry of Education under the Education and Training Act 2020. The Ministry of Education regulates performance, funding and support agencies, including the Tertiary Education Commission and the New Zealand Qualifications Authority (NZQA) (delegated to Universities New Zealand for universities). This results in universities, institutes of technology/polytechnics, and other providers of health professional programmes being subject to parallel compliance systems.

The reforms across the health and disability sector are taking place alongside an extensive process of change in the education sector. All polytechnics, institutes of technology and work-based (including apprenticeship) education providers have been consolidated into a new, centralised New Zealand Institute of Skills and Technology, known as Te Pūkenga. This new national institute oversees a revised structure for vocational qualifications and how they are accessed by students (Fisher and Leder, 2022; Hannigan and Asmatullayeva, 2022). Several health professional education programmes are offered by education providers within Te Pūkenga, including medical imaging, midwifery, nursing, occupational therapy and physiotherapy, involving a significant proportion of the future workforce.

All of these major sector changes are underpinned by a desire to address inequity,

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especially for Māori and in the light of the Health Services and Outcomes Kaupapa Inquiry (Waitangi Tribunal, 2019) and critique of He Korowai Oranga (the Māori Health Strategy) (see Came, Herbert and McCreanor, 2021). Critical workforce challenges and the need for high-quality and relevant services, including health professional education, also inform these changes (Health and Disability System Review, 2020; Health Workforce Advisory Board, 2022). The many complexities of this environment are summarised in Table 1, which presents an overview of the legislation, ministries and agencies involved in, or with influence over, health professional education.

Tertiary education providers offering programmes leading to health professional registration navigate overlapping and duplicated quality assurance systems which traverse the education and health and disability sectors. An example of this is the relationship between programme accreditation and tertiary education sector quality assurance processes. The first function of the responsible authorities defined by the Health Practitioners Competence Assurance Act directly relates to the education of health professionals and

states that the authority is empowered 'to prescribe the qualifications required for scopes of practice within the profession, and, for that purpose, to accredit and monitor educational institutions and degrees, courses of studies, or programmes' (s118(1)(a)). This function has been interpreted by the authorities in ways that result in complex and expensive accreditation and monitoring processes, including gazetted fees for site visits (Shaw and Tudor, 2021, 2022). The same education providers are also subject to the requirements of the tertiary education sector quality assurance processes, including accreditation and monitoring of their programmes, which incorporates consultation with and feedback from the workforces the programmes serve. The education and health sector quality assurance processes include very similar requirements, resulting in duplicated activities and costs. This overlap is noted by Universities New Zealand: 'professional registration bodies are ... keenly interested in the content and quality of education ... and many stipulate monitoring and periodic review visits ... An application process for approval from such a body may overlap with [Universities New Zealand] processes ... but the two are separate review and approval processes' (Universities New Zealand, 2021, p.16).

Despite the number of government agencies, legal requirements and separate quality assurance processes involved, significant quality challenges remain. As with any large and complex bureaucracy, there is a risk of fragmentation, with many strategies, projects and reports being developed in different areas. This creates the potential for coincidental initiatives, actions and policy, resulting in inefficiency and waste in financially constrained sectors (Rhodes, 2016). Within such an environment there is a risk that innovative solutions to current challenges become disconnected, resulting in multiple parallel actions (Lapuate and Suzuki, 2020).

Two key reports have identified challenges and opportunities to address them. The Health and Disability System Review (2020) considered the existing services and opportunities to transform the system. This provided a cornerstone for the transformation of the health and disability system, with the establishment of new national structures replacing district health

Table 1: Brief overview of the health and education landscape of Aotearoa New Zealand (legislation, agencies and initiatives)

Sector	Act	Administered by	Agencies/entities	Involvement in/influence on workforce education			
				Funding/strategic direction	Development/quality assurance	Content/context of curricula	Education providers
Health, disability and wellbeing	Pae Ora (Healthy Futures) (July 2022)	Ministry of Health	Health Workforce Directorate	Taskforces for medicine, nursing, midwifery, allied health			
			Te Ao Marama (External advice on implementation of Whāia Te Ao Mārama: The Māori Disability Action Plan)			Content	
			District Health Boards (disestablished)				Placements for clinical/practical learning and assessment
			-Health New Zealand -Māori Health Authority				
	New Zealand Public Health and Disability Act 2000		Health Workforce Advisory Board	Strategic oversight and advice			
			Health Quality Safety Commission			Content	
	Health Practitioners Competence Assurance Act (2003, 2020)		Responsible Authorities (18, with some incorporating more than one profession)		Accreditation, approval and monitoring of qualifications	Content and requirements (eg. clinical learning hours, restrictions on credit)	Extensive compliance
	Health and Disability Commissioner Act (1994)		Health and Disability Commissioner's Office			Essential content/context	
Mental Health and Wellbeing Commission Act (2020)		Mental Health and Wellbeing Commission					
Accident Compensation Act (2001)	Ministry of Business, Innovation, and Employment	Accident Compensation Corporation					

boards (including the first national Māori Health Authority) and of Whaikaha – Ministry of Disabled People. The most recent annual report of the Health Workforce Advisory Board (2022) highlighted ongoing challenges between and across agencies. These two key reports made similar points about the need for

Māori, Pasifika and disabled communities to be better served, to have self-determination, to realise better outcomes and to be reflected in the workforce (and therefore professional education programmes). Both reports also noted the necessity for agencies and organisations across the sectors to engage with one

another in planning and delivering services and engaging in the education of health professional students. See Table 2 for a summary of key points.

Discussion

The education of the health and disability workforce is part of an ecosystem linking

Sector	Act	Administered by	Agencies/entities	Involvement in/influence on workforce education			
				Funding/ strategic direction	Development/ quality assurance	Content/ context of curricula	Education providers
		Ministry of Social Development	Whānau Ora/ Enabling Good Lives approaches to service design and delivery			Content/ philosophical position	
			Office for Disability Issues/ Ministry for Disabled People	Enabling Good Lives (radical change to resourcing and accessing support)		Content	
	Residential Care and Disability Support Services Act 2018		Needs Assessment and Service Co- ordination Services			Content	Context of placement/ clinical learning
Education	Education and Training Act (2020)	Ministry/ Minister of Education	Tertiary Education Commission – crown entity	Funding and resourcing education providers			
			NZ Qualifications Authority		Accreditation and monitoring of qualifications and education providers		
			Universities New Zealand				
			Universities		Approved internal quality assurance systems and processes (NZQA/ Universities New Zealand) and RA	Degree qualifications	
			Wananga			Degree and pre-degree education	
			Polytechnics and Institutes of Technology/Te Pūkenga				
			Private training providers		requirements – all requiring engagement with wider sector	Pre-degree qualifications	
Workforce Development Councils (previously industry/work- based training organisations)			Develop pre-degree vocational qualifications				

the health and disability sector, and the design, funding and delivery of educational programmes. Along with being at the nexus of the health and education systems, health professional education

demands meaningful engagement with and responses to inequity. Preparation of the workforce requires deliberate strategies to ensure that the demographic of the student group reflects the community,

and that the content of programmes and the educational journey for all students actively engages with context and culture, with students from Māori, Pasifika and disabled cultures being actively

Table 2: Workforce - related considerations from recent reports (emphasis added)

Issues	Health and Disability System Review (HDSR, 2020)	Health Workforce Advisory Board (HWAB Annual Report, 2022)
Health and wellbeing	need to partner across government and with other sectors to address inequity and improve outcomes, particularly for those for whom the current system is not working <i>Māori, Pacific peoples, disabled people</i> , people living in rural disadvantage and other vulnerable groups. communities or with socioeconomic disadvantage. (p.98).	The longstanding failure to address <i>Māori health workforce inequity</i> has failed Aotearoa New Zealand, failed Māori and Māori whānau (p. 13). Despite the various efforts by successive governments, there has <i>not been a significant shift in the equity concerns and the health and wellbeing of Pacific peoples</i> in New Zealand (p. 15). urgent health workforce development <i>needed to increase, legitimise and develop the disability workforce</i> (p.17).
Workforce	Workforce development is a <i>key constraint in our current health and disability system</i> . In line with worldwide trends New Zealand is experiencing growing clinical workforce shortages. Our system will not be sustainable unless we change models of care and use the workforce differently. (p.7).	Following communication between ministers, the Ministry's Health Workforce Directorate began working with officials at the Ministry of Education and the Tertiary Education Commission to <i>establish a mechanism to ensure health workforce sustainability</i> . (p. 5).
Tertiary education strategy	The Tertiary Education Strategy does not currently have a formal position on tertiary training for the health workforce. In future, it <i>should have a more explicit plan to grow the health workforce, in line with the health and disability workforce plan</i> (p. 185).	... There are at least a dozen health professions, trained at undergraduate level and funded by the Tertiary Education Commission with overall policy responsibility sitting with the Ministry of Education, which are <i>at risk of not meeting health workforce demands</i> (p.5).
Tertiary education providers	there are concerns that New Zealand's professional bodies, Responsible Authorities, and training organisations have <i>created higher training and entry barriers than other countries</i> (p. 190).	Several agencies and organisations have different roles and accountabilities in the education, training and regulation of the health workforce. The <i>policy drivers of education providers are often not in alignment with the needs of the health sector</i> and coherent, holistic workforce development. (p. 5).
Curricula	...growing need for work-integrated learning to <i>align training with the changing needs of workplaces</i> and allow students to learn-as-they-earn. (p. 187).	The health sector has no influence on the level of support offered by education providers to <i>ensure that students that admitted to programmes of study actually stay the course and graduate</i> (p.5).
Clinical/ placement		
Health professional regulators (RAs)	no additional Responsible Authorities should be established and <i>the current regulators should be encouraged to work more collaboratively in a way that is consistent with the workforce plan</i> and to better support agreed health and disability system objectives. (p. 194).	The Board continues to be concerned that the <i>17 Responsible Authorities responsible for 24 regulated professions have full autonomy in setting accreditation standards, but without the consequent responsibility for policy settings relating to accreditation standards, which are required for a responsive, pressured and changing health sector</i> . (p.6).

supported to achieve and succeed. Despite a lengthy history of consideration given to workforce issues (Gorman, Horsburgh and Abbott, 2009; Health Workforce Advisory Committee, 2003; Rees et al., 2018; Rees, 2019), critical issues remain. These issues, including cultures of institutional racism and distrust of westernised health systems, must be contextualised in the wider health, wellbeing and disability landscape of Aotearoa New Zealand, and the formal relationship between Maori and the Crown (Health and Disability System Review, 2020; Health Workforce Advisory Board, 2022).

Safety of the public is a priority, and it is reasonable that publicly funded agencies and services meet quality standards. The functions of the responsible authorities listed in the Health Practitioners Competence Assurance Act primarily, and understandably, emphasise public safety. However, regulating the health workforce does not guarantee that all registered health professionals will practise safely (see Dyer, 2005). Therefore, while regulation through competence-based registration may be intended as a measure to deter unacceptable practice, it is not infallibly able to prevent

unsafe, illegal or dangerous practice in and of itself.

The various quality processes have many similarities in their requirements, and are resource intensive because of their discrete approaches. The associated expenditure, along with very fine-grained requirements set by some responsible authorities, such as a prescribed number of clinical placement hours that students must complete (Shaw and Tudor, 2021), combine to limit the number of places available in health professional programmes. The cost of meeting

duplicated, and often very detailed, quality assurance requirements has a detrimental effect on the capacity of educational institutions to contribute to addressing workforce issues. While ensuring quality and safety is critical in the health environment, educating sufficient health workers who are appropriately prepared to engage with the community and respond to their needs is equally important. Ensuring that the education system can deliver a fit-for-purpose workforce to the health and disability sector requires a review of the duplicated function of parallel compliance requirements enacted within this complex bureaucracy.

It is clear that there is a good deal of information about what is required to provide high-quality education to meet the workforce needs of the health and disability sector. Te Whatu Ora has established a taskforce to accelerate workforce development (Te Whatu Ora, 2022). Its website refers to working with education providers, regulators and employee organisations. These groups may be thought of as 'islands', with their unique perspectives and expertise in relation to workforce development and practice. Other 'islands' include the ministries of Health and Education, the Mental Health and Wellbeing Commission, Whaikaha – Ministry of Disabled People, the Tertiary Education Commission, NZQA, Universities New Zealand and Te Pūkenga. All of these agencies need to be engaged in considering how to address health workforce issues.

There is limited literature that discusses inter-agency collaboration, but trust is recognised as a critical factor in bringing about and embedding change (Essens et al., 2016), and particularly change which influences people's working lives (Hastings et al., 2014). Without open communication, it is impossible to connect, find common purpose and engage meaningfully. To that end, we suggest four bridges that may help to link these islands of expertise. These bridges provide a framework for creating shared understanding and navigating between the islands of expertise where there are differing points of view and priorities. Building and maintaining these bridges may require dedicated roles that are designed with the express purpose of

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establishing and maintaining connection and engagement, and ensuring that meaningful communication occurs and voices are heard.

Bridge one: person-centred equity

Ensuring that people and equity are at the heart of health professional education and practice is imperative. Te Tiriti o Waitangi is the founding document of Aotearoa New Zealand and for that reason it should underpin the design and delivery of services and the education of their associated workforces. The inequitable outcomes Māori experience clearly indicate a failure to enact te Tiriti o Waitangi, inadequate responses to previous initiatives, including

He Korowai Oranga, and the need to pay attention to the Waitangi Tribunal kaupapa inquiry (Waitangi Tribunal, 2019; Came, Herbert and McCreanor, 2021).

The Critical Tiriti Analysis tool (Came, O'Sullivan and McCreanor, 2020; Kidd et al., 2022) references the four articles of te Tiriti and can be used to guide intentional and purposeful policy design oriented to achieving equity. Central to this is a person- and whānau/family-centred approach to care, support and resources that transcends rigid boundaries between agencies and services and is mindful of equity. Whānau Ora is an example of an approach to service design and provision that prioritises meaningful links across agencies (Durie et al., 2010). This was also the philosophical basis of the Enabling Good Lives initiative, the implementation of which will bring radical change to how disabled people access support and resources under the auspices of Whaikaha – Ministry of Disabled People (Shaw and Sherrard, 2022).

Ensuring that people and their experience, cultural context and access are all genuinely addressed is critical to addressing inequity. The education of health professionals must engage with the expertise of those with experiences of services to address persistent inequitable outcomes. A person-centred and equity-based approach provides a sound foundation for health workforce education, making connections with and between people, and across the boundaries between agencies and organisations.

Bridge two: expertise recognition

There are many 'stakeholders' in the health and disability sector, including those whom the system is designed to serve (the Health Practitioners Competence Assurance Act refers to them as 'consumers'), regulators, education providers, and health and disability service providers. The voices that struggle to be heard the most are those of people accessing and experiencing services (Elliott, 2017; Rees et al., 2018). Given the appreciation of the inequity experienced by Māori, Pasifika people and the disabled community, the assertion of the voice of the community (Elliott, 2017) and reviews of service provision (Mental Health and Wellbeing Commission, 2022; Waitangi

Tribunal, 2019), it is timely to define expertise. One approach is to prioritise expert voices in relation to specific issues or situations. Our suggestion is that the 'lead' voices are identified as follows:

- *consumers of services* – the expert 'voice' of consumers is that of groups representing their communities (rather than service providers or 'experts' within the sector);
- *education of the workforce* – the expertise in design, delivery and quality assurance of education programmes to educate and develop the workforce is that of educators;
- *regulation of practitioners* – the expertise in relation to the regulation of practitioners and oversight of their ongoing competence is that of health professional regulators;
- *work readiness of the workforce* – the expertise in relation to requirements of work readiness and nurturing of new graduates is that of employers and service provision agencies.

Recognising the 'lead' expertise in decision making, planning and action will limit overlap, duplication and confusion. This bridge would require mechanisms for communication and decision making between the experts from each area of responsibility. Defining the lead expertise in relation to educational design and practice is imperative to address overlap and duplicated resources between the health and education sectors. This, along with reconsidering some of the very rigid programme criteria instituted by some responsible authorities, has the potential to increase access to, and enhance the journey through, health professional education programmes, ultimately increasing the number of graduates, and among them graduates who have a profile that reflects the wider community.

Bridge three: crossing professional and institutional barriers

The settings and scopes in which health professionals learn and practice have the potential to constrain their experience, interests and opportunities. Prioritising interprofessional learning and practice experiences, finding ways to develop and extend relationships between students/practitioners and employers, rethinking the

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emphasis on research within professional learning, and recognising similar skill sets across scopes of practice all have the potential to assist with workforce challenges.

The value of interprofessional learning and practice is well established and core to many health professional education programmes in Aotearoa (see Boyd and Horne, 2008; Jones, McCallin and Shaw, 2014). Beyond engaging across professional boundaries, there are also opportunities to bridge educational and practice environments. Clinical learning placements that incorporate exposure to professional diversity in health teams are instrumental in translating interprofessional learning into practice. Student scholarships can develop relationships that evolve beyond study into

an employment journey (Gómez-Ibáñez et al., 2020). Transitioning early-career professionals into practice is key to workforce retention and may include internships, specific first-year programmes (as in midwifery: see Dixon et al., 2015), and preliminary professional registrations (as in other professional fields, such as teaching).

There are also opportunities to consider career development that is broad rather than deep. The current model of professional learning is tightly linked to postgraduate education, with an emphasis on research (Kesten et al., 2022). This is appropriate for many practitioners and essential to contribute knowledge to fields of practice. However, it is also driven to some degree by access to research funding for the higher education sector. This could be considered a perverse incentive which emphasises research outputs and recognition (Gair et al., 2021). Professional learning opportunities that enable practitioners to develop their practice and contribute to the sector do not necessarily require that they undertake research.

Opportunities to broaden career interests across professional boundaries in similar fields (such as nursing/paramedicine/anaesthetic technology) should be possible when there are clear links in the skill set and knowledge base across the professions. This could be achieved by recognising the transferability of existing skills and knowledge as the basis for additional scopes, with a focus on the needs of the community, rather than the established territories and boundaries of professions (Fraher and Brandt, 2019; World Health Organization, 2010). Opportunities for combined or multiple registrations, enabling practitioners to practise in more than one role or scope, would be very cumbersome to manage across the current siloed, responsible authority structure and systems.

This bridge requires thinking beyond the boundaries of professions, established roles and structures, and considering broader options for practitioners to develop their practice and careers. Opportunities for practitioners to extend their skills (including 'skill shifting') and interests assist with workforce retention, particularly in rural areas (Franco, Lima and Giovanella, 2021). More flexible

approaches to role development and recognition have the potential to enable access to a wider range of services and support, offered by professionals who have been able to extend their interests and skill sets.

Bridge four: role innovation

There are a number of opportunities for role innovation within the health and disability workforce. Workforce shortages, transitions to extended scopes in some professions, increasing population demand and, more recently, the effects of the Covid-19 pandemic highlight the need to consider options. Opportunities and the need for innovation in primary care have been explored in some detail (see Moore, 2019). One example of innovation is the primary care practice assistant demonstration (Adair, Adair and Coster, 2013). It is timely to (re)consider other innovations, such as second-tier roles, peer workforce development and apprenticeships.

Second-tier roles are also referred to as assistant or auxiliary roles within the health and disability sector. Professional and policy positions have seen such roles move in and out of favour over time. In New Zealand, the establishment, rise, fall and re-implementation of enrolled nurses is a good example of this (Davies and Asbery, 2020). Prior to the Health Practitioners Competence Assurance Act in 2003, some professions, which are now regulated under the Act, were framed as non-regulated auxiliaries. Oral health therapists are one example of a professional group that has transitioned from non-regulated to regulated status. More recently, the podiatry profession has recognised the potential of assistants to support access to services for the community.

The development of the peer workforce is a recognised approach in the mental health and wellbeing space (Health Workforce Advisory Board, 2022). One of the strengths of this model is that it recognises, values and engages with the voices of those with lived experience. The voice of the disabled community is also emphasised in the Enabling Good Lives approach (Shaw and Sherrard, 2022), which includes the role of a 'kaitūhono' or 'connector', accompanied by the

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expectation that members of the disabled community will be well equipped and supported to enter this workforce.

Apprenticeship-based models of workforce education and development are becoming more popular and enable students to be engaged with the sector as they learn and achieve educational credentials. Over several decades the education of the health and disability workforce moved from practice-based settings into educational institutions. This served the purpose of emphasising

evidence-based practice and prioritising the educational journey, while also raising the profile of knowledge and science to inform practice. The disadvantage has been the loss of a deep connection with the workforce and environments that graduates need to navigate. The strengths of apprenticeships are that they ensure that learning is grounded in practice, reduce the need for students to work while studying, and contribute to the workforce while also establishing potential connections between employers and future employees (Bernstein, 2021). It is timely to consider some middle ground in the educational journey, which reconsiders the settings in which learning takes place. The qualifications that students would achieve may take longer to complete within apprenticeships, but they would still be awarded by accredited educational institutions and carry the same professional status.

All of these role innovations require rethinking our current design and approaches to educating the workforce and managing across professional and practice boundaries. They have the advantage of enabling flexible approaches to learning and pathways into practice. Flexibility is one of the key elements of enabling engagement of students who have strong affiliations and commitments to their communities (Duder, Foster and Hoskyn, 2022). There are opportunities for new roles that are grounded in and defined by the needs of communities and with skill sets that are complementary to (and therefore supportive of) existing registered health professional scopes of practice. If education providers were less constrained by discipline and professional silos, which are perpetuated by the extent to which some responsible authorities interpret their oversight of education, there would be more opportunity to develop roles and pathways in response to community need and context.

Conclusion

Within the context of significant change across the health and disability and education systems, and major concerns about the workforce, we undertook a brief analysis of the range of legislation, agencies and key reports that relate to educating the regulated health professional workforce.

There is a range of expertise, reports and initiatives, but little opportunity for them to be linked, which is detrimental to workforce planning. Key reports note that the workforce is critical to addressing inequitable outcomes and should reflect the communities being served, along with opportunities for better connection between health professional regulators, educators and clinical service (placement) providers.

Plans for health workforce development cannot be predicated on the idea of simply educating more people within established and regulated professions. Structural changes currently underway in the health and disability system and education sector

of Aotearoa New Zealand make it timely to address some of the complexities and frustrations that exist across the myriad agencies, legislation, requirements and initiatives that inform the current workforce planning, development and education landscape. There is extensive expertise across these sectors and agencies; we have conceptualised these as 'islands' of expertise, because of challenges in relation to how they connect. We suggest four 'bridges' which may assist with these connections, the four bridges being person-centred equity, expertise recognition, crossing professional and institutional barriers, and role innovation. These bridges provide a framework for linking across the

existing islands of expertise and reducing overlapping and competing systems which have a negative impact on the workforce pipeline. Creating and establishing roles that make human connections across the bridges and between the islands would be essential to their success. The reasons for the current disconnections are unlikely to be a lack of expertise, but rather of opportunities and mechanisms to work across agencies, boundaries and initiatives. Finding ways through these challenges, particularly in relation to health professional education, has the potential to make a positive impact on workforce planning and development.

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2022 SIR FRANK HOLMES MEMORIAL LECTURE IN POLICY STUDIES

DEVELOPING FUTURE PUBLIC SERVICE LEADERS FOR AOTEAROA NEW ZEALAND


Dr Ashley Bloomfield

The New Zealand public service performance compares very well internationally, and this has been evident during the global COVID-19 pandemic. The public service will need strong and adaptable leadership in future to respond effectively to significant global challenges and threats to public trust, and there is a need for better public policy responses to extant 'wicked' problems. The pandemic response in New Zealand and internationally provides strong pointers as to what New Zealand should do to develop public service leaders for the future.


WHEN Wednesday 23 November 2022
6–7 pm lecture
7–8 pm refreshments

WHERE Lecture Theatre 1 (GBLT1), Government Buildings, Pipitea Campus
55 Lambton Quay, Wellington
The lecture will also be livestreamed into Lecture Theatre 2.

RSVP Email lyne.todd@vuw.ac.nz or phone 04 463 9492
by Sunday 20 November 2022



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