



ASSOCIATION OF SALARIED MEDICAL SPECIALISTS
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Submission to the Ministry of Health on the Draft Mental Health and Addiction Workforce Action Plan 2016-2020

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Background

The Association of Salaried Medical Specialists (ASMS) is the union and professional association of salaried senior doctors and dentists employed throughout New Zealand. We were formed in April 1989 to advocate and promote the common industrial and professional interests of our members. We now represent more than 4,000 members, mostly employed by District Health Boards (DHBs) as medical and dental specialists, including physicians, surgeons, anaesthetists, psychiatrists, oncologists, radiologists, pathologists and paediatricians. Over 90% of all public hospital senior doctors and dentists eligible to join the ASMS are in fact members.

Although most of our members work in secondary and tertiary care (either as specialists or as non-vocationally registered doctors or dentists) in the public sector, a small but significant number work in primary care and outside DHBs. These members are employed by the New Zealand Family Planning Association, ACC, hospices, community trusts, iwi health authorities, union health centres and the New Zealand Blood Service.

The ASMS promotes improved health care for all New Zealanders and recognition of the professional skills and training of our members, and their important role in health care provision. We are committed to the establishment and maintenance of a high quality, professionally-led public health system throughout New Zealand.

The ASMS is an affiliate of the New Zealand Council of Trade Unions.

Summary

- The draft Mental Health and Addiction (MH&A) Workforce Action Plan acknowledges “New Zealand’s health workforce is ... characterised by staff shortages. There are workforce supply pressures arising from a range of factors, including an ageing health workforce, and reliance on overseas-trained health professionals ... There are also current shortages within critical specialist areas and anticipated future shortages in some specialist areas, and some rural and provincial areas are experiencing ongoing supply and demand gaps.”
- The draft Action Plan also acknowledges that: “Challenges related to supply pressures, are compounded with an increasing demand for services. It is expected that there will be a doubling in service demand for mental health and addiction services by 2020.” Further, “There are increasing chronic long-term conditions and co-morbidities, impacting on what and how healthcare is delivered.”
- Despite these acknowledgements, all actions to deal with workforce issues in the draft are ‘tentative’, due largely to funding availability.
- The Association of Salaried Medical Specialists (ASMS) considers actions to address workforce shortfalls are a ‘must’, not optional ‘extras’ if the funding is available. The Ministry of Health needs to emphasise this by spelling out the consequences – in relation to unmet needs and consequent costs – of not fully implementing the Action Plan.
- There is an opportunity here for the Ministry of Health to demonstrate strong leadership. Instead of passively accepting that funding may not be available to implement the Action Plan, the Ministry needs to advise on how funding pressures can be mitigated by making a compelling evidence-based case for investing in the health workforce now for medium and longer term health and economic benefits. This should form the basis of the Action Plan.
- Good mental health and wellbeing have been shown to result in health, social and economic benefits for individuals, communities and populations, including:
 - better physical health;
 - reduction in health-damaging behaviour;
 - greater educational achievement;
 - improved productivity;
 - higher incomes;
 - reduced absenteeism;
 - less crime;
 - more participation in community life;
 - improved overall functioning; and
 - reduced mortality.
- The Department of Health in the United Kingdom provides an example of how to produce a ‘business case’ for investing in MH&A services. To reinforce the British Government’s mental health services strategy in England, the Department commissioned supporting research from the London School of Economics (LSE) to make an economic case for the actions contained in the

strategy. Their economic modelling includes details on the costs of upfront investments to implement specific actions in the strategy along with evidence-based estimates of consequent substantial savings to the National Health Service (NHS) and wider economic benefits over the medium to longer term.

- Increasing the capacity of the New Zealand specialist workforce must be a top priority. The need for more specialists is not only urgent for covering gaps in services but also for training supervising and supporting new specialists and other health professionals, especially when the intention is to develop a more diverse team of health professionals in a more integrated system.
- A coherent approach to increase the attractiveness of specialist mental health roles in the workplace is critical, including a strong commitment to recruitment and retention measures based on developing attractive environments and conditions in which to practise.
- The specialist workforce capacity needs to be as such to enable specialists to provide the most effective and cost-efficient service. In this respect it is vital that specialist staffing levels are sufficient to enable specialists to have time for distributive clinical leadership and to provide patient centred care, including time for discussion with patients and their families about treatment options and their potential consequences and to encourage and empower people to be more involved in their health and wellbeing. Research shows that these measures not only improve patient outcomes and improve cost-efficiency but also have a positive flow-on for recruitment and retention of staff.
- While the draft Action Plan by implication seeks to shift MH&A workloads from secondary care to primary care, it fails to acknowledge the current shortages in the primary care workforce, which does not meet current needs let alone be expected to meet projected future needs. Nor does the Action Plan recognise that an under-resourced secondary care specialist workforce increases pressure on primary care services. Both primary and secondary care workforces need to be developed to enable timely access to MH&A services as needed.
- The ASMS welcomes the draft Action Plan's recognition of the need to strengthen the workforce for addiction services, including specialists working in the field. The need is urgent as there is a relatively small and rapidly ageing workforce of medical officers and specialists working in the fields of addictions and unless there is now a concerted recruitment effort we face serious service gaps within the next few years, especially in the field of opioid substitution treatment, where access to services is already problematic.

General comments

The ASMS welcomes this opportunity to comment on the draft Mental Health and Addiction (MH&A) Workforce Action Plan, though we are unimpressed with the short timeframe and the time of the year for consulting on such a vital subject.

We also note the Action Plan “has been developed with a strong commitment to align with the Mental Health and Addiction National Population Outcomes Framework (Outcomes Framework) and the Commissioning Framework for Mental Health and Addiction (Commissioning Framework)”. These frameworks, however, are still work in progress.

Most importantly, we note: “All actions in the draft are tentative,” due largely to funding availability. While we recognise the Ministry of Health does not determine the level of health funding, we strongly urge the Ministry to provide more candid advice on the resources required to implement this Action Plan, including the risks of under-resourcing.

As the draft plan points out (p 8):

New Zealand’s health workforce is highly skilled and professional but characterised by staff shortages. There are workforce supply pressures arising from a range of factors, including an ageing health workforce, and reliance on overseas-trained health professionals.

There are also current shortages within critical specialist areas and anticipated future shortages in some specialist areas, and some rural and provincial areas are experiencing ongoing supply and demand gaps.

Challenges related to supply pressures, are compounded with an increasing demand for services. It is expected that there will be a doubling in service demand for mental health and addiction services by 2020.

There are increasing chronic long-term conditions and co-morbidities, impacting on what and how healthcare is delivered.

The begging question is what would happen if the issues outlined here are not addressed. The plan must acknowledge:

- the consequences for patients and their families of not providing adequate resources to meet their needs;
- the consequences for workforce demand and supply; and
- the cost to the health system, other social services and the wider economy.

The consequences do not bear thinking about. Clearly, the issues must be addressed; they are not optional ‘extras’ if there is money left over from health spending elsewhere. This needs to be stated unequivocally.

Investing now for future health and economic gains

In the Foreword to the recent draft *Update of the New Zealand Health Strategy*, the Director-General of Health, Chai Chuah, says: “I recognise the way forward will require us all to think and act differently. For the Ministry of Health, that means we need to clarify our leadership role in the system, how we interact with others and how we focus our efforts to make improvements in the system.”

There is a good opportunity here for the Ministry of Health to demonstrate strong leadership, and to think and act differently. Health funding is always a challenge for any government, and the Ministry is in a key position to advise on how funding pressures can be mitigated by making a compelling case for investing in the health workforce now for medium and longer term health and economic benefits. This should form the basis of an action plan because, as the draft document implies, without funding there is no action plan.

The Department of Health in England have shown how this can be done.

To reinforce the British Government's mental health services strategy in England, the Department commissioned supporting research from the London School of Economics (LSE) to make an economic case for the actions contained in the strategy.^{1 2} Their economic modelling includes details on the costs of upfront investments to implement specific actions in the strategy along with evidence-based estimates of savings to the National Health Service (NHS) and wider economic benefits over the medium to longer term.

The Department of Health recognised that the wider economic costs of mental illness outweigh the direct costs of health services (and that both are increasing).³ In England, for example, total mental health service costs, including NHS costs and social and informal care costs, amounted to £22.5 billion in 2007, but the wider economic costs are estimated at £105.2 billion each year.⁴ The Department also acknowledged the wealth of research showing there is potential for substantially reducing the latter figure by investing more in the former.

Good mental health and wellbeing have been shown to result in health, social and economic benefits for individuals, communities and populations, including:

- better physical health;
- reduction in health-damaging behaviour;
- greater educational achievement;
- improved productivity;
- higher incomes;
- reduced absenteeism;
- less crime;
- more participation in community life;
- improved overall functioning; and
- reduced mortality.^{5 6 7 8}

The Department of Health says there is increasingly robust evidence that a range of innovative and preventative approaches can reduce mental health services costs by improving outcomes and increasing quality. This can be achieved not just for mental health and addiction services but also for other health services, since mental illness is associated with significant morbidity.

This is reinforced by the Health Workforce New Zealand-sponsored Mental Health and Addiction Workforce Service Review of 2011, which reported that people are presenting with increasing complexity, mental health issues, physical health issues, addictions, and stress, and that "the health outcomes for people with combinations of mental health and long-term physical conditions are substantially worse than either mental or physical conditions in isolation".⁹

Interventions to improve mental health can prevent physical health problems and promote recovery with associated economic savings. (Interventions to improve physical health can also prevent associated mental health problems and promote recovery, as people with long-term physical conditions and unexplained medical symptoms are at higher risk of mental health problems.)

The Department of Health in England has found different types of intervention can promote benefits over the short, medium and longer term and often in areas other than health. For instance, the majority of economic savings from investment in mental health promotion for children and families often accrue through reductions in crime and improved earnings. By contrast, reducing the number of people who miss their appointments may decrease immediate costs to the NHS.

The LSE's modelling shows, for example, that an additional investment of £327 million over 10 years for early detection services for people with prodromal symptoms of psychosis (At Risk Mental State-ARMS) can create savings of £653 million for the NHS alone, plus £142 million for other public services, and benefits of more than £1.2 billion for the wider economy. The additional investment includes funding for contacts with psychiatrists, use of medication and provision of cognitive therapy.

Similarly, an additional investment of £57 million over 10 years in multidisciplinary teams (eg, psychiatrists, psychologists, occupational therapists, community support workers, etc) providing early intervention services for people with psychosis can save the NHS £348 million, plus wider public sector and economic savings of £257 million.

While not going as far as the LSE's analysis, the Mental Health and Addiction Workforce Service Review recognised the financial benefits of timely interventions.¹⁰ Despite having limited time and resources, the review working group made a valiant attempt at modelling future health needs and the required resources to meet them for a range of patient groups under different scenarios. The group acknowledged the modelling was a preliminary effort but suggested each patient group "could be the subject of intensive modelling...that would have high utility in understanding the impact of alternative models of care and work force roles, types and functions."

The subsequent Ministry of Health Mental Health and Addiction Service Development Plan of 2012 makes little mention of the working group's report other than to say: "It provided a *first step* towards estimating future workforce numbers and competencies, identifying the implications for education, training and supervision, and developing a plan to address these needs."¹¹

We presume that the current proposed 'Action Plan' represents the 'second step', be it four years later. Notwithstanding that the review working group produced some useful work in restricted circumstances, the problem with their work (and that of all other medical workforce review groups commissioned by HWNZ) was that they were asked to find an answer to the wrong question – ie, how to develop a sustainable workforce that can meet a doubling of health needs over the next decade but with only 30% to 40% more health funding. Wrong questions produce wrong answers. Rather than taking a 'second step' based on the idea of doing more for less, the work of the review group and the Ministry's Service Development Plan should be adapted to a new approach focused first and foremost on meeting needs, and doing so as efficiently as possible, based on the growing body of financial and economic evidence that supports upfront investment.

A better question would be: What resources are required to meet New Zealand's mental health and addiction needs effectively and how can we make the best use of each health dollar to reduce the projected future economic costs of ill health.

It makes financial sense to invest in building and maintaining good mental health and resilience for communities, families and individuals and to provide the most effective and affordable services at times when they are needed.

– UK Department of Health¹²

Owing to the time restriction the remainder of this submission is confined to brief comments on: the hospital specialist workforce shortages; patient centred care; distributive clinical leadership; workforce shortages in primary care, and the addictions workforce.

Specialist workforce shortages

Increasing the capacity of the specialist workforce must be a top priority. The need for more specialists is not only urgent for covering gaps in services but also for training supervising and supporting new specialists and other health professionals, especially when the intention is to develop a more diverse team of health professionals in a more integrated system. As the MH&A workforce review report explains, this will require specialists “to have reduced ‘active’ caseloads” but growing clinical work pressures do not allow this. Nor do reduced DHB training budgets.

The ASMS supports, in principle, the aims to which this Action Plan aspires (though they do not go far enough), including empowering patients and their families, developing better coordinated approaches to care, including specialists providing more support for primary and community-based services, and better and more equitable access to services. But this simply will not happen if specialists are unable to find time to train and supervise other staff and provide support to patients so they may be more involved in their mental health, or have the capacity to respond to growing clinical need.

The MH&A Service Workforce Review points out that “as we continue to diversify our mental health workforce, we will need to find ways to both increase the supply [of psychiatrists] and better utilise and leverage the capacity we have and retain them with attractive environments in which to practice”. We agree. We also agree with the working group’s assessment that it is critical there is a “coherent approach to increase the attractiveness of specialist mental health roles in the workplace”.

While demand for specialist skills continues to rise there is a continuing trend of declining supply in key roles such as psychiatry. Our specialist workforce is aging and we are dependent on imports to supply our needs. Psychiatry provides the core of our specialist services and even as we continue to diversify our mental health workforce, we will need to find ways to both increase the supply, better utilise and leverage the capacity we have and retain them with attractive environments in which to practise.

MH&A Workforce Service Review Working Group¹³

However, the Action Plan’s response to meeting specialist workforce needs is very weak. The statement that: “*Developing the workforce through ongoing training opportunities and quality training modules will enable the specialist workforce to be responsive to people with mental health and/or addiction issues*” [p 11] is unrealistic. Better training opportunities (if that is what this statement means) would be welcome, but that alone will not address specialist workforce shortages.

The proposal to “*Implement targeted recruitment, retention, learning and development strategies for specialist workforce groups*” would also be welcome, but this merely echoes statements that have been made over many years, without adequate action.

A great deal more substance is needed to explain what these strategies must involve, and the investment needed to implement them, if the Action Plan is to realise the vision where, among other things, five years from now:

- The specialist mental health and addiction workforce shortages are addressed and the specialist workforce can meet the demand for mental health and addiction services.
- The numbers of New Zealand-trained specialists have increased and the need to employ

overseas trained specialists, in particular psychiatrists, is reduced.

- Specialist mental health and addiction expertise is accessible and available to the primary health and community care workforce, and wider health workforce.

There are opportunities to invest in strategies which, international evidence shows, not only help to achieve recruitment and retention goals but also improve service quality and patient outcomes, while at the same time reduce costs.

These strategies include adopting a patient centred care approach to organising and delivering services and properly implementing the government policy of clinical leadership.

Patient centred care

Specialists need quality time to enable discussion with patients and their families about treatment options and their potential consequences, and to encourage and empower people to be more involved in their health and wellbeing.

This is especially important given our health services are facing increasing numbers of patients with chronic and complex needs.

Research shows there are many benefits from patient centred care when it is properly implemented. When healthcare administrators, clinicians, patients and families work in partnership, the quality and safety of care rises and provider and patient satisfaction increase. Recent research indicates that a patient centred approach can also make health service delivery more efficient.¹⁴

Specific benefits include decreased mortality, decreased emergency department return visits, fewer medication errors and reductions in both underuse and overuse of medical services. In the care of patients with chronic conditions, studies indicate that patient centred approaches can increase both patient and doctor satisfaction, increase patient engagement and task orientation, reduce anxiety, and improve quality of life.¹⁵

A patient centred care approach is also seen as integral to preventative care.¹⁶

Further, it has been acknowledged that to succeed, a patient centred care approach must address staff needs, as the staff's ability to care effectively for patients is compromised if they do not feel cared for themselves. Once the patient centred care approach is firmly established, a positive cycle emerges where increased patient satisfaction increases employee satisfaction, and this in turn improves employee retention rates and the ability to continue practising patient centred care.¹⁷

Limited resources in the form of underfunding, low staffing levels and low morale in already overstretched systems are a perceived barrier to the practice of patient centred care.¹⁸

An underlying reason why a comprehensive patient centred care approach has not been well established in New Zealand's District Health Boards (DHBs), despite all of these benefits and more, is that it requires an upfront investment in services, especially in the medical specialist workforce.

While patient centred care is mentioned briefly in the Action Plan, it requires much greater emphasis and detail on implementation if it is to become more than a feel-good slogan.

Distributive clinical leadership

There is a significant opportunity to improve the cost-efficiency and effectiveness of our health services, including MH&A services, by giving a stronger commitment to distributive clinical leadership.

There is now a strong body of evidence showing how comprehensive clinical leadership can achieve what New Zealand's successive attempts at health reform have failed to achieve: significantly improve the effectiveness and efficiency of our public hospitals across the whole spectrum of services (not just the selected few targeted by Government) while managing the increasing costs of health care.

Indeed, given the health indicators for the coming decade, including those outlined in the draft Action Plan, the ability of our health system to meet the growing demands may well rest on the extent to which comprehensive clinical leadership is established in practice.

Quite simply, the reforms we need are only likely to be successful if clinically led.

– Professor Des Gorman, Executive Chair, HWNZ¹⁹

Successful clinical governance, as envisaged by the Government's *In Good Hands* policy statement and by the *Time for Quality* agreement between the ASMS and the country's DHBs, requires distributive leadership embedded at every level of the system.^{20 21}

Some of the many specific benefits of distributive clinical leadership include:

- Effective and efficient development of new innovative service models
- Quality training and supervision
- Sustainable achievement of government health targets
- Improved safety and quality of services and outcomes

For this to succeed in any meaningful way, financial investment is needed to develop the capacity of the specialist workforce to enable 'time for quality'.

Despite the many benefits of distributive clinical leadership, and support by successive governments, it has been ignored in the draft Action Plan. We strongly recommend that this is rectified in the final document.

Workforce shortages in primary care

The ASMS recognises that to achieve high-quality patient centred care stronger collaboration and coordination of services is required at every level. That means viewing the health system not so much in terms such as 'primary care' and 'secondary care' etc, but as a single continuum, with care provided by integrated multidisciplinary teams. We also recognise however, that like the hospital specialist workforce, the general practitioner workforce is also experiencing shortages, as acknowledged by HWNZ and the Minister of Health.^{22 23}

This is not acknowledged in the proposed Action Plan, even though a clear underlying theme is a shifting of the MH&A workload from secondary care to primary care.

The ASMS understands care of patients with mental illness is a significant part of the workload of primary care services. But, as the MH&A Workforce Service Review working group points out, while the primary care workforce may be competently handling a wide range of MH&A issues, the general practitioner and primary nursing workforces “usually had limited mental health training/experience...[and] the current model of care and funding model for primary care is centred around brief consults that are generally too short to enable MH&A issues to be effectively assessed and plans of care to be developed”.

The working group also says, “The development of the primary mental health initiatives have shown that focused and relevant training can provide substantial lifts in capability and confidence. New roles are developing in primary based mental health clinical support roles; specialist depression nurses, health psychologists we need to enhance and expand these roles.”

This requires funding.

Further, as mentioned earlier, hospital specialist staff are expected to provide significant support within primary care and community settings. The working group points out: “This will require these staff to have reduced 'active' caseloads and to be supporting and supervising groups of primary/community care workers to support people without the need for formal entry into specialist services.”

Reducing hospital specialist caseloads when there are already shortages of MH&A hospital specialists is clearly problematic and probably self-defeating. Part of the current pressure on primary care services, for instance, is due to difficulties obtaining timely referrals to specialist services. We understand that secondary mental health services are running at 100% capacity in some areas, so there is no room for flexibility, or for developing more efficient service models.

The Action Plan’s approach of shifting resources from secondary care to primary care is therefore too simplistic. There is a need to recognise that an under-resourced secondary care service will increase the workloads of the primary care services. Both sectors require adequate funding.

Addictions services workforce

The ASMS welcomes the draft Action Plan’s recognition of the need to strengthen the workforce for addiction services, including specialists working in the field. The need is urgent as there is a relatively small and rapidly ageing workforce of medical officers and specialists working in the fields of addictions and unless there is now a concerted recruitment effort, we face serious service gaps within the next few years, especially in the field of opioid substitution treatment, where access to services is already problematic.

We note the Ministry of Health’s advice to the Government on proposed amendments to the Misuse of Drugs Act 1975 that: “The small number of registered doctors in addiction treatment means that access to OST [opioid substitution treatment] is difficult and often is delayed more than is medically and socially appropriate.” Consequently, the Ministry says there is “significant unmet need for OST”, estimating that about 5,000 people who are addicted to opiates are not accessing the programme.²⁴ A Cabinet paper suggests this may amount to about half of the people in New Zealand who were opioid dependent, but only 60 people were on the OST waiting list as at December 2012.²⁵

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